Management in the Department of Health and Welfare

Evaluation Report
February 2006

Office of Performance Evaluations
Idaho Legislature

Report 06-01

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Rakesh Mohan, Director
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Rakesh Mohan
Director

February 23, 2006

Joint Legislative Oversight Committee
Idaho Legislature

Last October, you directed us to review the Department of Health and Welfare's management to (1) assess how well the department is performing some of its key management functions, and (2) identify areas within the department that may warrant further in-depth review. I am pleased to present this report to you, and hope that you and other members of the Legislature will find it useful in making policy and budget decisions.

The report provides the results of a comprehensive survey of the department's nearly 2,800 permanent employees. Their views shed light on some key indicators of organizational climate and management effectiveness, such as communication, morale, turnover, and job satisfaction. The report also discusses the methods used by the department to assess workload and make staffing decisions, the role of the Board of Health and Welfare, and issues relating to facility planning, maintenance, and funding.

This report presents the department with an opportunity to look into its operations and work toward addressing issues raised by its employees, such as low morale, high turnover, excessive workload, and concerns about the openness of communication within the department. These issues are important, and, if not addressed, can affect the services of the state's largest agency—responsible for the health and safety of some of Idaho's most vulnerable citizens.

We thank Director Karl Kurtz and his staff at the department for their cooperation. Our special thanks to everyone at the department who helped us develop the surveys and to the many employees who took time to complete them.

Sincerely,

Rakesh Mohan

Rakesh Mohan

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Executive Summary

Management in the Department of Health and Welfare

The Department of Health and Welfare is Idaho's largest state agency, and is responsible for various programs that serve Idaho's most vulnerable citizens. Sound management of the department is critical to ensure citizens receive needed services and resources are used efficiently. This report assesses department management, and identifies potential areas for future evaluation work.

Many department employees reported that workplace morale is poor, and turnover data showed that the agency turnover has exceeded the state average. Staff identified a number of factors that they believe contribute to both morale problems and turnover. These factors included pay, the level of stress at work, workload, and management.

Staff ratings of management and communication within the department were mixed. Staff concerns tended to focus on upper management, with more than 40 percent reporting they lacked confidence in upper management decision-making and almost half indicating they could not talk openly with upper management about work-related problems without fear of retaliation. We also found that management's efforts to monitor workload and assess staffing needs were limited in a number of large program areas.

The report also examines the role of the Board of Health and Welfare, and found that the board has a more limited role than do the boards that oversee a number of Idaho's other large agencies. Finally, the report discusses the department's facility maintenance efforts.

Legislative Interest, Study Scope, and Methodology

In March 2005, the Joint Legislative Oversight Committee directed the Office of Performance Evaluations to conduct a review of management within the Department of Health and Welfare. The request for an evaluation came from the chair of the House Health and Welfare Committee, who raised questions about the size of middle management, methods used to allocate staffing resources, fiscal management, intra-agency communication, and the role of the Board of Health and Welfare.

In October, the Joint Legislative Oversight Committee approved the scope of the study. The purpose of the report is to provide information that will (1) help lawmakers better understand how department management is doing with respect to some of its key functions, and (2) identify areas that may require further study.

We used various methods to gauge the performance of management and identify areas that may require additional study. One of our primary methods was to survey *all* staff, supervisors, and middle managers about their perceptions of agency management, communication, and morale. We received responses from 1,946 of 2,606 staff and frontline supervisors (75 percent) and 143 of 159 middle managers (90 percent). We also reviewed the methods management uses to monitor workload and assess staffing needs within the department, analyzed agency turnover data, reviewed the department's communication methods, reviewed information about the role of the Board of Health and Welfare, and examined facility planning efforts.

About Our Surveys

We conducted separate surveys of (1) staff and frontline supervisors, and (2) middle managers. For readability, we sometimes use the generic term "staff" when referring to staff and frontline supervisors, and the term "managers" when referring to middle managers.

Department Overview

The Department of Health and Welfare is Idaho's largest state agency both in terms of funding and staffing. For fiscal year 2006, the department was appropriated $1.6 billion, with 64 percent coming from federal funds and 29 percent from the state general fund. For this fiscal year, the department was authorized more than 3,000 full-time positions. The agency has offices around the state and administers a wide range of important programs such as Child Welfare, Food Stamps, Medicaid, Substance Abuse, and Mental Health.

The department's upper management team includes the director, who is appointed by the Governor, three deputy directors, six division administrators, seven regional directors, and directors of three residential institutions operated by the department: the Idaho State School and Hospital, State Hospital North, and State Hospital South. The department also employs 159 middle managers, who manage programs and department staff statewide.

Staff Gave Mixed Ratings to Department Management

As part of our review, we surveyed agency staff for their perceptions of management within the Department of Health and Welfare. More than twice as many respondents said they had confidence in the management skills and abilities of upper management than said they did not. In addition, a majority of

those surveyed felt agency policies and procedures were adequate to guide them in their work, and that they received sufficient training for their current assignment.

However, 41 percent of staff and supervisors responding to our survey said they lacked confidence in upper management decision-making, and a majority believed upper management does not regularly monitor workload or make staffing adjustments when necessary. Survey responses received from middle managers were similar to the feedback received from agency staff.

Many staff also expressed concerns about the fairness of management decisions regarding raises and promotions, and more than 60 percent did not feel the department rewards employees on the basis of merit and performance.

Many Employees Reported Poor Morale

Workplace morale is an important factor in organizational effectiveness. Management needs to be cognizant of employee morale and foster a positive work environment because morale is often considered vital to meeting organizational goals, and can impact staff productivity and turnover.

We asked agency staff and managers for their perceptions of morale within the Department of Health and Welfare. Overall, about a third rated morale among their co-workers as good or very good. In contrast, 39 percent of staff and supervisors rated morale as poor or very poor, and 28 percent rated it as fair (the middle value on a five-point scale).

Staff identified various factors that negatively impact morale. Pay was the most commonly mentioned factor, and was ranked among the top factors impacting morale by 64 percent of staff and supervisors. Other key factors identified as impacting morale included the level of stress at work, workload, and management.

Morale was highest in the Division of Health and the three divisions that provide indirect support services (Management Services, Human Resources, and Information and Technology Services). Morale was lowest in the Division of Welfare, where just 29 percent of staff and supervisors rated morale as good or very good, and 45 percent rated morale as poor or very poor. Morale also appeared to be somewhat low in the Family and Community Services and Medicaid divisions. In each of these divisions, more staff said morale was poor or very poor than said it was good or very good.

Employee ratings of individual job satisfaction (a measure of an employee's satisfaction with specific job characteristics, workplace environment, schedule, sense of purpose, and perception of making a difference) were generally higher than ratings of morale. In most program areas, a majority of survey respondents said they were generally satisfied with their jobs.

Overall, Staff Rated Agency Communication as Fair; Many Raised Concerns About the Openness of Communication with Upper Management and Feared Retaliation

Communication is an important element of effective management, especially in an organization as large as the Department of Health and Welfare. Department management uses various methods to communicate with employees, including regularly held meetings, written policies, and an internal computer network that employees can access for news and program information.

As part of our survey, we asked staff to rate communications within the department. Overall, 42 percent rated communication as fair (the middle value on a five-point scale), while 24 percent rated it good or very good and 34 percent rated it as poor or very poor. Staff generally gave high marks to communication with their co-workers and immediate supervisors. They also felt the department's intranet system—called *Infonet*—is a useful source of information. Staff gave somewhat lower marks to communication with upper management, with roughly a third of respondents indicating they do not receive enough information from top management to do their jobs well.

Many staff raised concerns about the openness of communication within the department. Almost half of staff responding to our survey disagreed or strongly disagreed with the statement: "The atmosphere in my program encourages people to be open and candid with management." A similar percentage did not feel they could talk openly with upper management about work-related problems without fear of retaliation.

Efforts to Analyze Workload and Staffing Are Limited in Key Program Areas

One of management's key responsibilities is to ensure the most cost-effective use of staffing resources. We examined the extent to which the department utilizes empirical analyses, caseload standards, workload models, and other systematic approaches that can be valuable for analyzing staffing needs and making management decisions.

We found several major program areas do not currently employ well-developed workload models to assist in making staffing decisions. These programs have methods in place that are limited in their ability to assess staffing needs, identify the most cost-effective work processes, and allow the department to react optimally to changes in funding levels. We also found that managers of the state's three inpatient institutions had questions about how to achieve efficient staffing and scheduling, but did not have the necessary data or analytical resources to address the issue.

Our survey of department staff and supervisors showed that many believed their current workload is excessive. Nearly half of those responding to the survey disagreed or strongly disagreed with the statement "I generally have enough time to do the work assigned to me." Staff identified workload as one of the factors that most impacts morale and turnover within the department.

Turnover Has Exceeded State Average

Like morale, turnover can be used as an indicator of organizational health and management effectiveness. High employee turnover results in high recruitment and training costs and can negatively impact morale and productivity. In recent years, the Department of Health and Welfare's overall turnover rate has exceeded the average turnover rate in state government. In fiscal year 2005, the department's turnover rate was 17.5 percent.

Department staff identified a number of reasons why employees leave the department. As with morale, the most commonly mentioned reasons were pay, the level of stress at work, workload, and management. Pay was cited as one of the top reasons employees leave the department by 85 percent of staff and supervisors responding to the survey.

Our analysis of turnover in specific divisions, programs, and work locations within the department showed that turnover varies, sometimes considerably, depending on the area within the organization. For instance, turnover rates ranged from a low of 10 percent in the Division of Human Resources to a high of 19.4 percent in the Division of Family and Community Services. Turnover was generally highest in the Treasure Valley and at State Hospital South in Blackfoot.

The department has not monitored turnover for specific divisions, programs, and locations. Because of turnover variances among division and programs, it would be useful for management purposes to monitor turnover at these levels.

Board of Health and Welfare Has a Limited Role Compared to Some Other Idaho Boards

The Board of Health and Welfare is authorized by Idaho Code, and consists of seven members who are appointed by the Governor with the consent of the Senate. The board's primary responsibilities include adopting and amending agency rules related to the protection of public health and acting as a hearing board for persons aggrieved by actions of the department.

In contrast to some other Idaho boards, the Board of Health and Welfare has a limited role. The board meets less often—about four times per year—than many of the boards overseeing other large state agencies. In addition, the board is not

active in fiscal, policy, and administrative issues as is the Board of Correction and Board of Juvenile Corrections. Finally, unlike the Board of Environmental Quality, the Board of Health and Welfare does not review *all* agency rules, focusing only on rules that impact public health.

Facility Planning

The Department of Health and Welfare operates three residential institutions for individuals who have severe mental illnesses or developmental disabilities. The facilities include: the Idaho State School and Hospital in Nampa, State Hospital South in Blackfoot, and State Hospital North in Orofino.

We found the department is at risk of, or is presently experiencing, problems with facility maintenance and repair because some key best practices are not in place. We also note that the department is not taking full advantage of federal financial participation in paying for buildings and equipment.

It is unclear, however, whether the issues that have come to our attention are limited to the department, or whether they are more systemic within state government. The Legislature may wish to consider further study in this area, and as one option, focus on Department of Health and Welfare institutions as a case study.

Recommendations

As mentioned previously, the primary purposes for the report were to (1) help lawmakers better understand how department management is doing with respect to some of its key functions, and (2) identify areas that may require further study. Because of the short timeframe for this review, we could not conduct in-depth analysis in all areas of management. As a result, recommendations are presented only in selected areas. Report recommendations include:

Chapter 4

4.1: The Department of Health and Welfare should:

a. Examine the causes for employees' lack of confidence when communicating with management.

b. Take steps to address these concerns and build two-way communication between staff and management by examining structures and policy language of the employee grievance resolution process, and encouraging intermediate and informal alternatives for staff.

Chapter 5

5.1: The Department of Health and Welfare should leverage its expertise and experience to set standards for and to develop more useful workload and staffing models for programs that would benefit from them.

5.2: The Department of Health and Welfare's Division of Welfare should evaluate the reasons for staff perceptions that workload adjustments are not made when needed, and include an evaluation of options and expected results of applying alternative methods of balancing workloads among offices.

5.3: The Department of Health and Welfare should evaluate alternatives, including the development of in-house analytical capacity, to assist the state hospitals in identifying the most cost-effective staffing, allocation, and scheduling methodologies.

Chapter 6

6.1: The Department of Health and Welfare should make changes to the structure of its personnel data to allow for regular monitoring of turnover rates in specific divisions, programs, and work locations, as well as by job classification.

Potential Areas for Further Study

We identified a number of program areas that may warrant more in-depth review based on the results of our surveys and other evaluation work:

- **Benefits**—Staff reported excessive workload, low morale, and that employees were not rewarded on the basis of merit. They also raised concerns about management decision-making and communication.

- **Child Welfare**—Staff reported high workload, low morale, and poor communication. The Office of Performance Evaluations completed an evaluation of the program in 2005, and the department has initiated efforts to make program improvements.

- **Facility Standards**—Staff indicated this program was understaffed and employees were not rewarded on the basis of merit. Staff also reported low morale and raised concerns about communication.

- **Idaho State School and Hospital**—Staff raised concerns about intra-agency communication, management decision-making, and indicated they felt undervalued by the department. The hospital also had the second highest turnover rate in the department.

- **Physical Health Services**—Staff reported low morale, and raised concerns about the grievance resolution process, communication, management decision-making, and merit-based rewards.

- **State Hospital North**—Staff reported this institution was understaffed and employees were not rewarded on the basis of merit. Staff also indicated that morale was low and said they felt undervalued by the department.

Response to the Evaluation

We requested and received written responses to this report from the Office of the Governor and the Department of Health and Welfare. The responses are included at the end of the report along with our comments.

Acknowledgments

We appreciate the cooperation and assistance we received from the Department of Health and Welfare and the Board of Health and Welfare in conducting this study. We also appreciate the input we received from the following entities:

- Budget and Policy Analysis
- Office of the Governor
- Division of Financial Management
- Office of the State Controller
- Department of Administration
- Idaho Division of Human Resources

Ned Parrish (project lead), Paul Headlee, Chris Shoop, Rachel Johnstone, and Courtney Haines of the Office of Performance Evaluations conducted the study. Staff members AJ Burns, Amy Lorenzo, and TJ Thomson performed quality control for the project, and Margaret Campbell did the desktop publishing.

Assistance was provided by six consultants:

1. Ross Burkhart, Ph.D., Associate Professor and Chair, Department of Political Science, Boise State University
2. Greg Hill, Assistant Professor and Director of the Applied Research Program, Department of Public Policy and Administration, Boise State University
3. Tedd McDonald, Ph.D., Associate Professor, Department of Psychology, Boise State University

4. Mary Pritchard, Ph.D., Assistant Professor and Director of Health Psychology Division, Department of Psychology, Boise State University
5. Kathleen Sullivan, Ph.D., Professor and Director of the Center for Educational Research and Evaluation, School of Education, University of Mississippi
6. Bob Thomas of Robert C. Thomas & Associates. Mr. Thomas is also Senior Principal Management Auditor, King County Auditor's Office, Seattle, Washington

Chapter 1
Introduction

The Department of Health and Welfare is Idaho's largest state agency, with more than 3,000 employees and an annual budget of almost $1.6 billion dollars. The agency has offices around the state and administers a wide range of important programs such as Child Welfare, Food Stamps, Medicaid, Substance Abuse, and Mental Health. This evaluation was conducted to address questions about management, morale and communication within the agency, and the role of the Board of Health and Welfare.

Organization and Staffing

The Department of Health and Welfare is comprised of seven divisions. Four of these divisions administer programs that provide services to clients, and the others provide indirect support services within the department. Responsibilities of each division include the following:

- **Family and Community Services**—Oversees the state's child protection system, as well as programs related to mental health, developmental disabilities, and substance abuse.
- **Health**—Administers various physical health programs through contracts with local health districts. Oversees and supports statewide emergency medical services. Operates the state's public health laboratory. Maintains vital statistics.
- **Medicaid**—Oversees the state's Medicaid and Children's Health Insurance programs. Licenses and inspects health care facilities, such as hospitals, nursing homes, and assisted living facilities.
- **Welfare**—Administers programs serving low-income individuals and families. Determines whether applicants are eligible for Medicaid benefits. Provides child support services.
- **Human Resources**—Recruits and retains department staff, coordinates workforce training and development, and oversees strategic planning.
- **Information and Technology Services**—Oversees the development of agency information systems, maintains department computer systems, and ensures the security of client information.

- **Management Services**—Performs administrative functions including managing the department's budget, overseeing accounting and reporting, processing payroll, and conducting internal audits and fraud investigations.

Department staff are located throughout the state in 7 regional offices and 34 field offices. Additional information about the department's major program areas is provided in exhibit 1.1.

The department operates three institutions for individuals requiring specialized residential care. State Hospital South, located in Blackfoot, provides psychiatric treatment and skilled nursing care for adults and adolescents with serious mental illnesses. State Hospital North, located in Orofino, is a psychiatric hospital that serves acute, court-committed patients. The Idaho State School and Hospital, located in Nampa, is designated as an intermediate care facility for the mentally retarded (ICF/MR) and serves the most severely impaired adults and adolescents with developmental disabilities. Administratively, these institutions fall within the Division of Family and Community Services.

The department is the state's largest agency in terms of total staffing. For fiscal year 2006, the department was authorized 3,021 full-time positions.[1] Department staff make up 18 percent of all state government employees. Exhibit 1.2 provides a breakdown of agency staffing by division and institution.

The agency is overseen by a 20-member executive leadership team that includes the director, three deputy directors, six division administrators, seven regional directors, and the administrators of the three institutions operated by the department.[2] Historically, regional directors were responsible for supervising staff assigned to regional or field offices. However, in 2002 division administrators in the central office were assigned direct responsibility for supervising regional staff in their program areas. This change was made to improve coordination and ensure more consistent delivery of services statewide. Regional directors now serve primarily as community liaisons.

The department also has a cadre of middle managers who are responsible for managing programs and department staff statewide. Middle management includes individuals in various position classifications including deputy division administrators, bureau chiefs, program managers, chiefs of social work, and area

[1] Includes 12 full-time positions that are allocated to the Council on Domestic Violence, the Council for the Deaf and Hard-of-Hearing, and the Developmental Disabilities Council, and are not directly part of the department.

[2] All members of the upper management team are non-classified. In addition, the department has four other permanent staff in non-classified positions. Three of these staff work in the department's public information office and one supports the Board of Health and Welfare.

Exhibit 1.1: Overview of Department of Health and Welfare Program Areas

Division of Family and Community Services

Adult Mental Health	Provides assessment, treatment, and rehabilitation for people with serious mental illness. Services include intensive treatment for those having severe psychiatric problems, and long-term services for those with significant on-going mental illness. Services are generally provided through state-operated regional community mental health centers and private providers.
Child Welfare	Investigates allegations of child abuse and neglect. Oversees the state's foster care system, adoption services, and the Independent Living Program that assists foster children in transitioning from foster care to independent adults.
Children's Mental Health	Provides outpatient, inpatient, and residential services for children with a serious emotional disturbance and their families. Services are primarily provided through contracts and agreements with private providers.
Developmental Disabilities	Oversees and provides services for citizens of all ages with developmental disabilities. The program includes an infant-toddler component to provide developmental services to children from birth to three years of age, a service coordination function for children with developmental disabilities from birth to 21 years of age, an intensive behavioral program for children with developmental disabilities exhibiting challenging behaviors, court required evaluations concerning people with developmental disabilities, and funding for families to care for individuals with developmental disabilities in the home.
Other	Includes staff who serve in more than one specific program within the Division of Family and Community Services, or oversee services that address substance abuse.

Division of Health

Emergency Medical Services	Oversees, regulates, and implements a statewide system designed to respond to medical emergencies. The program includes licensure and certification of responding emergency medical personnel, and awarding grants for training, patient care supplies, and equipment to local emergency medical service organizations.
Laboratory Services	Performs testing for communicable diseases, environmental samples, and bioterrorism materials. Also administers regulations pertaining to private medical laboratories.
Physical Health Services	Oversees programs that address particular health issues. Areas include programs that address sexually transmitted diseases, childhood immunizations, nutrition, women's health, trends in diseases, food safety, risk behavior prevention, chronic disease control, and environmental health concerns.
Vital Statistics	Responsible for the collection and dissemination of data such as births, deaths, marriage, divorce, chronic diseases, and health behaviors.

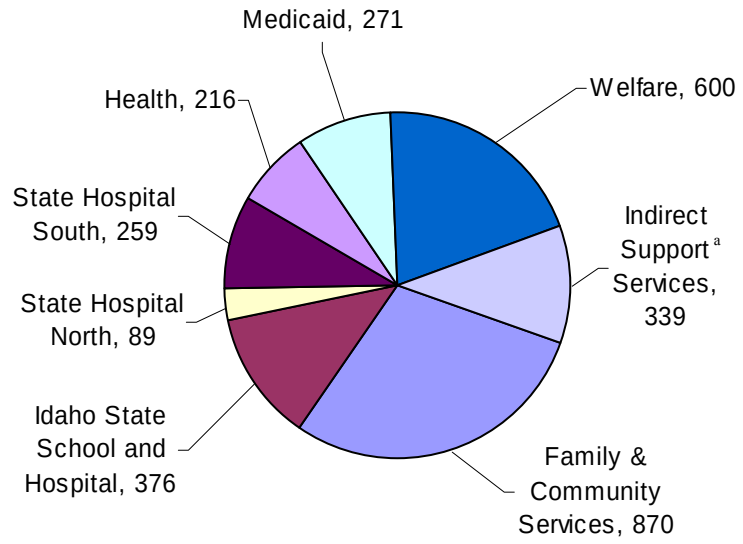
Continued on the next page

Exhibit 1.1—continued

Division of Medicaid	
Facility Standards	Responsible for the inspection and licensure of hospitals, nursing homes, and residential and assisted living facilities. Responsible for ensuring compliance with state and federal requirements.
Medical Assistance Services	Administers the programs that cover the costs of medical services for eligible citizens. Specific programs include Medicaid and Children's Health Insurance.
Division of Welfare	
Benefits	Administers programs that provide assistance in the form of cash, food, medical services, and child care. The programs include Food Stamps, Idaho Child Care Program, and Temporary Assistance for Families in Idaho. Also makes eligibility determinations for individuals applying for medical coverage under Medicaid.
Child Support	Provides services that include locating non-custodial parents, establishing paternity, enforcing parental financial obligations, and re-issuing collected child support payments.
Welfare Support	Includes staff that support both the benefits and child support programs, including administrative staff, staff conducting research and evaluation tasks, and contracts and external resource management staff.
Indirect Support Services	
Division of Human Resources	Responsible for the department's personnel and strategic planning matters. Provides services pertaining to equal employment opportunity, workforce and development, recruitment and retention, compensation, human resource policies and employee relations, and employee benefits.
Information and Technology Services Division	Responsible for technology applications within the department. Oversees information systems, information technology projects, and department hardware and infrastructure. Carries out technology planning and coordination services, and provides technical support throughout the department.
Division of Management Services	Responsible for the administrative services within the department. The functions of this division include financial and accounting services, contracts and purchasing, facilities management, and audits and investigations.
Office of the Director	Responsible for the overall direction of the department and public information needs. The office includes top-level management, public information staff, and related support staff.

Source: Office of Performance Evaluations' review of Department of Health and Welfare publications.

Exhibit 1.2: Authorized Positions in the Department of Health and Welfare, Fiscal Year 2006



[a] Includes 12 positions that serve independent councils and commissions.

Source: Office of Performance Evaluations' analysis of data from Legislative Budget and Policy Analysis, *Idaho Legislative Budget Book for Fiscal Year 2007;* and Department of Health and Welfare, *Facts/Figures/Trends 2005–2006*.

supervisors.[3] As of November 2005, there were 159 employees in positions we classified as middle management. These staff accounted for five percent of all department positions in fiscal year 2006. Staff in middle management positions were typically classified employees.

Budget

As shown in exhibit 1.3, the Department of Health and Welfare was appropriated nearly $1.6 billion for fiscal year 2006. Almost two-thirds of this amount was federal funding, with state general funds contributing 29 percent. After adjusting for inflation, agency funding increased 22 percent in the past four years. Much of the increase is due to growth in the state's Medicaid budget, which currently accounts for almost three-quarters of the department's total budget.

[3] We did not count frontline supervisors as middle managers because they provide direct supervision to line staff and may be assigned cases of their own or provide direct services to clients.

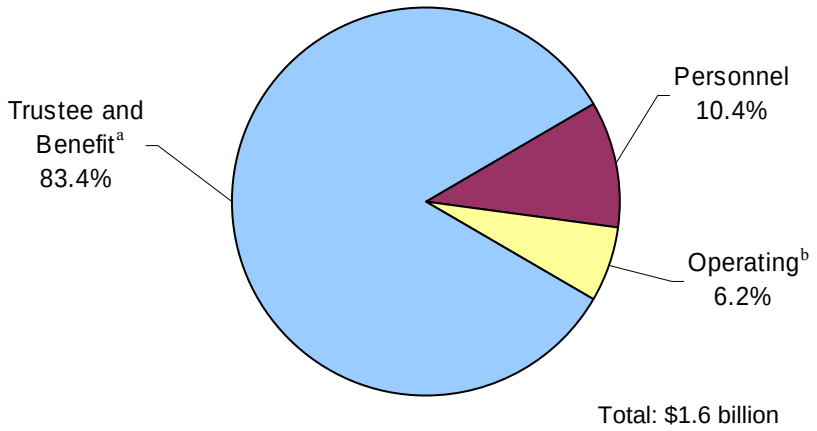
Exhibit 1.3: Annual Appropriations in the Department of Health and Welfare, by Fiscal Year

	2003	2004	2005	2006
General fund	$353,208,200	$360,810,800	$425,024,200	$457,682,300
Dedicated	76,255,000	85,007,000	112,439,900	115,433,800
Federal	786,326,100	795,055,300	976,013,300	1,024,457,900
Total	$1,215,789,300	$1,240,873,100	$1,513,477,400	$1,597,574,000

Source: Office of Performance Evaluations' analysis of data from Legislative Budget and Policy Analysis, *Idaho Legislative Fiscal Report for Fiscal Year 2005* and *Fiscal Year 2006*.

Much of the funding the department receives is designated for "trustee and benefit" costs, which include direct payments to clients and costs for client services. As shown in exhibit 1.4, 83 percent of the funding the department received for fiscal year 2006 was designated for these costs. Approximately $166 million, 10.4 percent of the department's total appropriation for fiscal year 2006, was allocated for agency personnel costs.

Exhibit 1.4: Department of Health and Welfare Fiscal Year 2006 Appropriation, by Expenditure Type



[a] Includes direct payments to clients and costs for client services.
[b] Includes $96,000 for capital outlay.

Source: Office of Performance Evaluations' analysis of data from Legislative Budget and Policy Analysis, *Idaho Legislative Fiscal Report for Fiscal Year 2006*.

Legislative Interest and Study Scope

In March 2005, the Joint Legislative Oversight Committee directed the Office of Performance Evaluations to conduct an evaluation of management at the Department of Health and Welfare. The request for an evaluation came from the chair of the House Health and Welfare Committee, who raised questions about the size of middle management, methods used to allocate resources, fiscal management, intra-agency communication, and the role of the Board of Health and Welfare.

Because of the broad scope of the request, the Joint Legislative Oversight Committee approved a multiphase review in October 2005, and asked that we complete the first phase of the project by February 2006. The purpose of this initial review is to provide information that will (1) help lawmakers better understand how department management is doing with respect to some of its key functions, and (2) identify areas that may require further study. A copy of the project scope is included as appendix A.

Methodology

We used various methods to address questions raised in the project scope, including the following:

- Conducted separate surveys of (1) staff and frontline supervisors, and (2) middle managers to obtain information about employee morale and their perceptions of management and communications within the department. In developing the questions used in the surveys, we sought input from more than 60 department employees who work in various program areas. We conducted group interviews in two separate regions and in the central office. We also asked staff in some of the department's smaller field offices to provide input via email.

  We used a web-based survey approach and included all permanent employees in the survey population. Overall, we received responses from 75 percent of the 2,606 staff and supervisors and 90 percent of the 159 middle managers surveyed. More specific information about response rates in individual divisions and program areas is provided in appendix B.

- Reviewed methods the department uses to assess its workload and estimate staffing needs. Visited the department's two largest institutions, the Idaho State School and Hospital and State Hospital South, and interviewed institutional managers and staff to obtain information about staffing patterns and facility planning.

- Interviewed members of the Board of Health and Welfare and reviewed board minutes to gain an understanding of the role and responsibilities of

the board. Gathered information about the role and responsibilities of boards addressing health and welfare issues in Idaho's six neighboring states and boards established to help govern other large agencies in Idaho.

- Interviewed agency managers to gain an understanding of the methods used to communicate with employees. Reviewed the department's strategic communications documents and information available to employees on the department's intranet.
- Analyzed employee turnover information obtained from the Office of the State Controller, the Idaho Division of Human Resources, and the Department of Health and Welfare.

Report Organization

The remainder of this report is organized as follows:

- **Chapter 2** provides information regarding staff perceptions of the quality and performance of management within the department.
- **Chapter 3** provides an overview of agency morale, and discusses factors that negatively impact morale.
- **Chapter 4** examines the methods the department uses to communicate with employees, and discusses staff perceptions of the quality of communication within the agency.
- **Chapter 5** reviews the department's efforts to assess program workloads and staffing needs, and discusses the need to establish more systematic and data-driven methods of analyzing workload and estimating staffing needs in key program areas.
- **Chapter 6** reviews employee turnover within the department and factors that staff believe contribute to turnover.
- **Chapter 7** discusses the role of the Board of Health and Welfare, and compares board responsibilities with those of other Idaho boards and similar boards in neighboring states.
- **Chapter 8** examines facility planning, maintenance, and funding at the Idaho State School and Hospital, State Hospital North, and State Hospital South.

Chapter 2
Staff Perceptions of Management

We surveyed agency staff and managers for their perceptions of management within the Department of Health and Welfare. Ratings of management within the department were mixed. More than twice as many respondents said they had confidence in the management skills and abilities of upper management than said they did not. A majority of respondents felt management provided sufficient training and that agency policies and procedures were adequate to guide them in their work. However, 41 percent of respondents reported they lacked confidence in upper management decision-making, and a majority of staff and supervisors said upper management does not regularly monitor workload or make staffing adjustments when necessary. Many staff also expressed concerns about the fairness of management decisions regarding raises and promotions, and more than 60 percent did not feel the department rewards employees on the basis of merit and performance.

The questionnaires we used to survey department staff and middle managers consisted of more than 40 items that addressed various topics including management, morale, communications, workload and staffing, and turnover. This chapter will address items related to agency management. Input received regarding morale, communications, workload and staffing, and turnover will be addressed in subsequent chapters of the report. A summary of survey responses provided by department staff and frontline supervisors is included as appendix C. Results from our survey of department middle managers are presented in appendix D.

About Our Surveys

We conducted separate surveys of (1) staff and frontline supervisors, and (2) middle managers. For readability, we sometimes use the generic term "staff" when referring to staff and frontline supervisors, and the term "managers" when referring to middle managers.

Survey Ratings Were Generally Positive for Management Skills and Leadership

Exhibit 2.1 shows how staff and supervisors rated the management skills and abilities of department frontline supervisors, program managers, and the upper management team. Ratings were generally higher for frontline supervisors and

Exhibit 2.1: Staff and Supervisor Confidence in Managers' Skills and Abilities

"I have confidence the following managers have the management skills and abilities needed to perform their jobs."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Upper management	49.4%	28.0%	22.6%	3.3
Program managers	63.3	19.7	17.0	3.6
Frontline supervisors	69.3	15.9	14.7	3.8

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

program managers than for upper management. However, even for upper management, more than twice as many respondents said they had confidence in management's skills and abilities than said they did not.

Ratings of leadership demonstrated by department managers tended to be slightly lower, but were still positive overall. As shown in exhibit 2.2, 41.5 percent of respondents rated the quality of upper management leadership as good or very good, while 28.5 percent rated upper management leadership as poor or very poor. Ratings for middle managers and frontline supervisors were higher, with 57.8 percent rating middle manager leadership as good or very good and 69.5 percent rating frontline supervisor leadership as good or very good.

Staff and Middle Managers Often Lacked Confidence in Upper Management Decision-Making

Many survey respondents gave low ratings to upper management decision-making. Overall, 41.4 percent of staff and supervisors responding to the survey reported they did not have confidence in upper management decision-making, while 31.1 percent said they did. More than a third of middle managers (37.9 percent) said they lacked confidence in upper management decision-making. The low ratings for management decision-making may indicate that although employees had generally positive perceptions of the people in department leadership positions, they were less supportive of management actions.

Exhibit 2.2: Staff and Supervisor Ratings of Quality of Management Leadership

"Please rate the quality of leadership provided to employees by each of the following levels of management within the Department of Health and Welfare."

	Good or Very Good	Fair	Poor or Very Poor	Average Rating[a]
Upper management	41.5%	30.0%	28.5%	3.1
Program managers	57.8	23.8	18.3	3.5
Frontline supervisors	69.5	19.6	10.9	3.9

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Confidence in management decision-making varied by program. Exhibit 2.3 shows the average confidence ratings for each division and major program area. Confidence in upper management decision-making was highest among staff in Child Support, Human Resources, and Welfare Support. Ratings of upper management decision-making were lowest among staff at the Idaho State School and Hospital, State Hospital North, and in the Benefits program. In Physical Health Services, ratings were also low, with a majority of respondents indicating they lacked confidence in upper management decision-making.

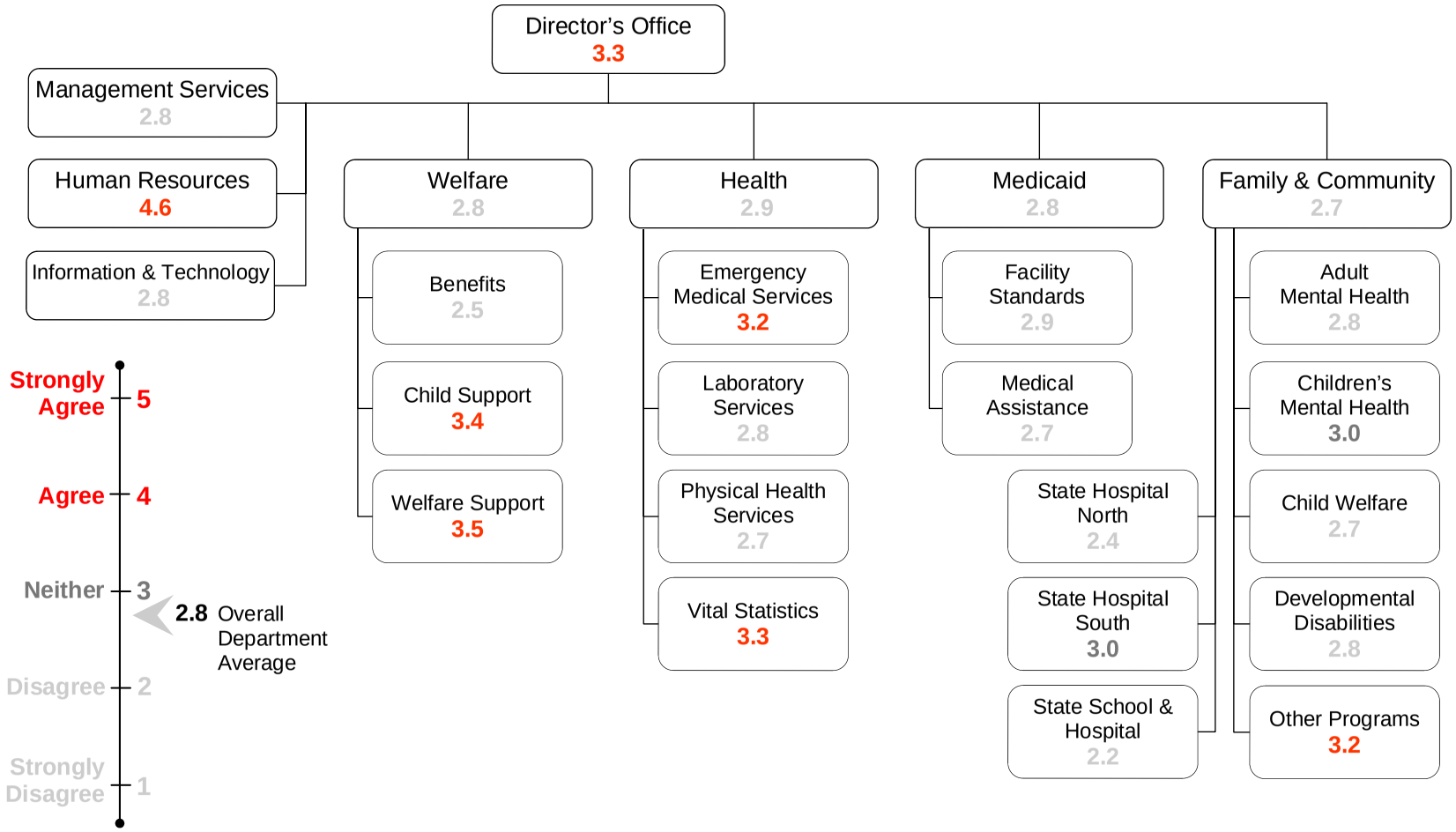
Many Staff Reported Upper Management Did Not Regularly Monitor or Adjust Workload

As part of our surveys, we asked staff and middle managers whether they believed management regularly monitors workload, and if management made adjustments to staff workload to the extent possible. Exhibit 2.4 presents staff responses to these survey items. Although nearly three quarters of respondents felt frontline supervisors regularly monitored workload, a majority of staff and supervisors reported upper management did not.

A slightly smaller share of respondents (63.3 percent) felt frontline supervisors made needed adjustments to staff workload. More than half of respondents (57.3 percent) disagreed or strongly disagreed when asked if upper management made necessary adjustments to workload.

Middle manager responses were similar to those of staff. About a quarter of middle managers responding to the survey felt upper management had a clear

Exhibit 2.3: Responses of Staff and Supervisors on Confidence in Upper-Management Decision-Making, by Division and Program



Note: Levels of agreement with the item "I have confidence in upper-level management decision-making," where 5 is strongly agree and 1 is strongly disagree.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Exhibit 2.4: Staff and Supervisor Ratings of Management Efforts to Monitor and Adjust Workload

"The following levels of management regularly monitor staff workload for my program."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Upper management	19.1%	28.9%	52.0%	2.5
Program managers	45.3	23.2	31.4	3.1
Frontline supervisors	72.9	12.8	14.4	3.8

"To the extent possible, the following levels of management make adjustments to staff workload when necessary."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Upper management	14.3%	28.4%	57.3%	2.3
Program managers	37.2	22.8	40.0	2.9
Frontline supervisors	63.3	15.4	21.4	3.5

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

understanding of the workload in their program area, but 53.9 percent did not. In addition, 45.1 percent of middle managers disagreed or strongly disagreed with the statement "Upper-level management distributes resources, including staff, appropriately to my program or unit."

Staff Ratings Were Generally Positive for Agency Training

Overall, 56.4 percent of staff and supervisors responding to our survey reported that they received adequate training for their current assignment, while 25.2 percent disagreed. Similarly, more than twice as many middle managers said they received adequate training than said they did not.

Ratings of training were lowest among staff in the Benefits program within the Division of Welfare. In this area, 34.3 percent felt training was adequate while 43.6 percent said it was not. Staff and supervisors in the Information and Technology Services division also gave relatively low ratings to training, with

38 percent indicating the training they received was adequate and 35 percent saying it was not.

Overall, a majority of staff and supervisors believed upper management encourages employee training, with 27.8 percent disagreeing. Perceptions of the extent to which upper management encouraged training varied by division. In the Division of Family and Community Services, 59.8 percent of staff and supervisors responding to the survey felt upper management encouraged training and 22.5 percent disagreed. In the Division of Welfare, 43.2 percent of respondents felt upper management encouraged training and 37.4 percent disagreed.

Survey Ratings Were Positive for Department Policies

Nearly two-thirds of staff and frontline supervisors responding to our survey (65 percent) felt the department had established adequate standards, policies, and procedures to guide them in their work. Ratings of department policies were fairly consistent from division to division. In addition, in all but one program area, a majority of staff and supervisors felt adequate policies were in place. The one exception was Benefits within the Division of Welfare where 49.5 percent of respondents indicated that necessary policy guidance was in place, and nearly one-third (31.6 percent) disagreed.

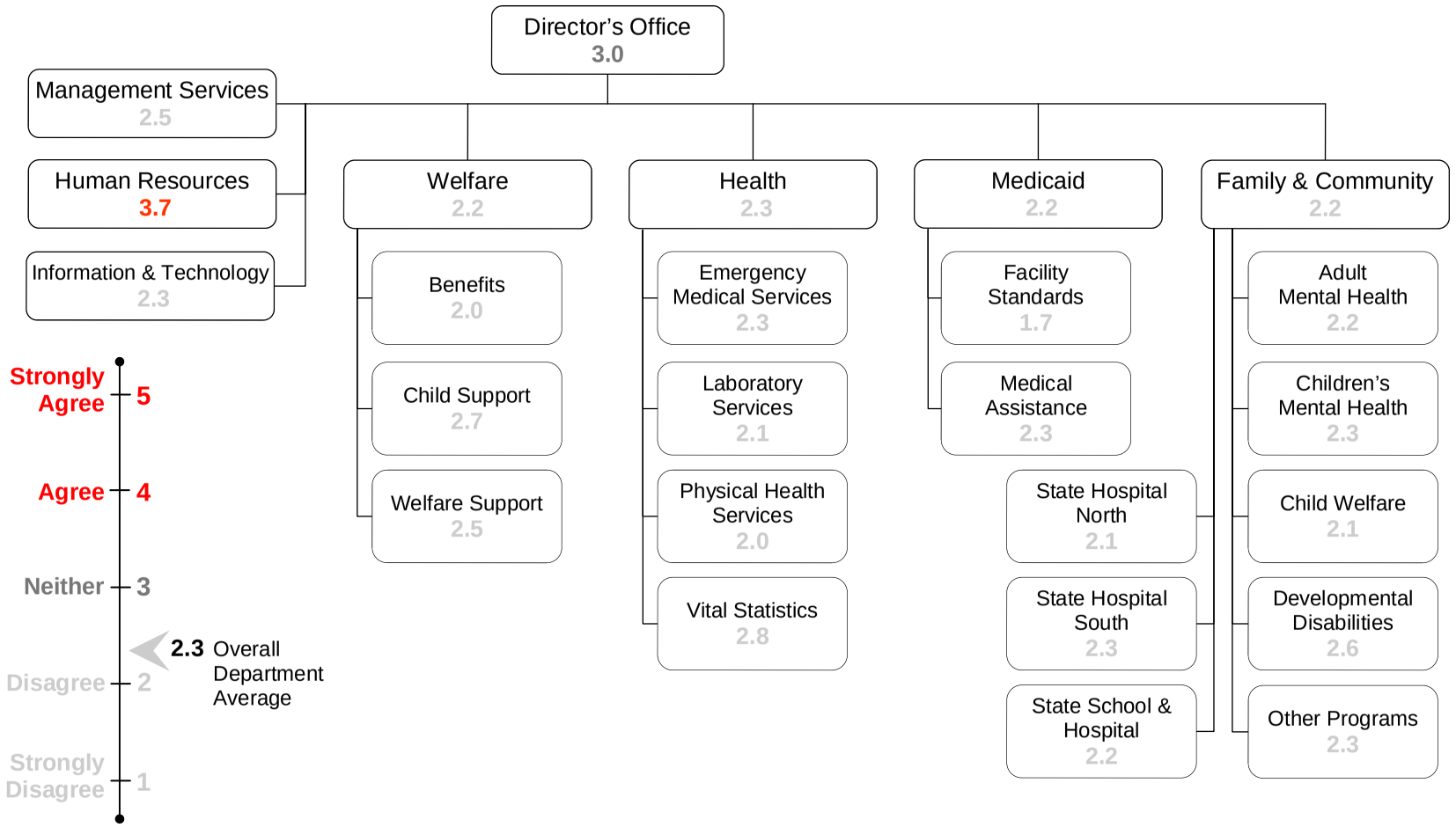
Policies of divisions within the department appear to be readily accessible to employees. Copies of standards and policies are generally available on the department's intranet, called the *Infonet*. This system, discussed further in chapter 4, is available to department employees statewide.

Many Staff Reported Management Does Not Reward Performance or Value Employees

As part of our survey, staff and frontline supervisors were asked whether the department rewards staff based on performance. Just 18.1 percent agreed or strongly agreed with the statement "The department rewards (not necessarily monetary) staff on the basis of merit and performance." In contrast, more than 60 percent of respondents disagreed or strongly disagreed with this statement. As shown in exhibit 2.5, concerns about management's efforts to reward staff were voiced most strongly in Facility Standards, where 82.9 percent said management does not reward employees on the basis of merit and performance.

Although a large majority (74.2 percent) of staff and supervisors reported that they feel valued by their supervisor, only about one-quarter (24.4 percent) said they feel valued by the department. Nearly half of all respondents (47.1 percent) said they did not feel valued by the department.

Exhibit 2.5: Responses of Staff and Supervisors on Whether the Department Rewards Staff on the Basis of Merit and Performance, by Division and Program



Note: Levels of staff and supervisors' agreement with: "To the extent possible, the Department of Health and Welfare rewards (not necessarily monetarily) staff on the basis of merit and performance," where 5 is strongly agree and 1 is strongly disagree.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Staff Often Questioned the Fairness of Management Decisions About Raises and Promotions

More than half (51.9 percent) of staff and supervisors responding to the survey disagreed or strongly disagreed with the statement "To the extent possible, decisions about the distribution of merit raises are made in a fair and equitable fashion." The level of disagreement was greatest in the Medicaid and Welfare divisions, where nearly 60 percent of staff and supervisors in each division disagreed.

Many staff and supervisors also raised concerns about the fairness of management decisions about promotions. Nearly half of survey respondents (46.7 percent) disagreed or strongly disagreed with the statement "To the extent possible, decisions about promotions are based on merit and performance." In contrast, just 29 percent agreed or strongly agreed.

Middle Managers Generally Reported Having the Authority They Need to Do Their Jobs Effectively

We asked several questions about whether managers were given adequate authority and opportunity to provide input regarding budget and staffing decisions impacting their program area. Middle managers generally reported that upper management provided sufficient authority and opportunities for input:

- More than two-thirds of middle managers said they had the authority they needed to do their jobs effectively.
- Nearly three-quarters of middle managers agreed or strongly agreed with the statement "I have the authority I need to appropriately allocate workload within my program or unit."
- A majority of managers felt they were given sufficient opportunity to provide input as the budget request for their program or unit is developed.
- A majority of middle managers indicated they had an appropriate level of control over the budget set for their program or unit.

Potential Areas for Further Study

Concerns about management were reported most frequently in four areas that may benefit from an in-depth review:

- Benefits, Division of Welfare
- State Hospital North in Orofino
- Idaho State School and Hospital in Nampa
- Physical Health Services, Division of Health

Chapter 3
Staff Morale

We surveyed agency staff, supervisors, and managers for their perceptions of morale within the Department of Health and Welfare. Overall, 39 percent of the more than 1,900 staff and supervisors responding to our survey rated morale as poor or very poor. In contrast, 33.1 percent rated morale as good or very good, and 28 percent rated it as fair (the middle value on a five-point scale). Middle managers generally gave higher ratings to morale, with just 14 percent rating morale as poor or very poor and more than half reporting that morale was good or very good. Key factors identified as impacting morale include pay, the level of stress at work, and workload. Employee ratings of individual job satisfaction were generally higher than ratings of morale. In most program areas, a majority of survey respondents said they were generally satisfied with their jobs.

Many Employees Gave Low Ratings to Workplace Morale

As part of our survey of staff, supervisors, and middle managers at the Department of Health and Welfare, we asked employees to rate workplace morale. Employees were to place the morale of their work group on a five-point scale from very good to very poor. Overall, about a third of staff and frontline supervisors responding to the survey rated morale as good or very good. In contrast, 39 percent rated morale as poor or very poor. The remaining 28 percent of staff and supervisors responding to the survey reported that morale was fair (the middle value on a five-point scale).

Interestingly, middle managers gave significantly higher ratings for workplace morale. More than half of middle managers responding to our survey rated the morale of the people they manage as good or very good, and just 14 percent rated morale as poor or very poor. The difference in the responses suggests a disconnect between managers and staff. Management may not have an accurate understanding of the work climate within the department.

Staff Ratings of Morale Varied by Division and Program

As part of our analysis, we looked at staff perceptions of morale by division and in the department's major program areas.

Comparison of Morale by Division

Morale ratings varied somewhat among divisions. As shown in exhibit 3.1, average ratings of workplace morale were highest in the Division of Health and the three divisions that provide indirect support services (Human Resources, Information and Technology Services, and Management Services).

Staff and supervisors in the Division of Welfare gave the lowest ratings for workplace morale. Here, just 29 percent of staff and supervisors rated morale as good or very good, and 45 percent rated morale among their co-workers as poor or very poor. Morale ratings were also low in the Family and Community Services and Medicaid divisions, where more staff rated morale as poor or very poor than good or very good.

Comparison of Morale by Program

Employee morale also varied substantially by program. Exhibit 3.2 presents the average morale ratings for each of the department's divisions and major program areas. Staff and supervisors in the Director's Office, Human Resources, and Vital Statistics gave the most positive ratings of co-worker morale. In each of

Exhibit 3.1: Staff and Supervisor Ratings of Workplace Morale, by Division

"Overall, workplace morale among my co-workers is:"

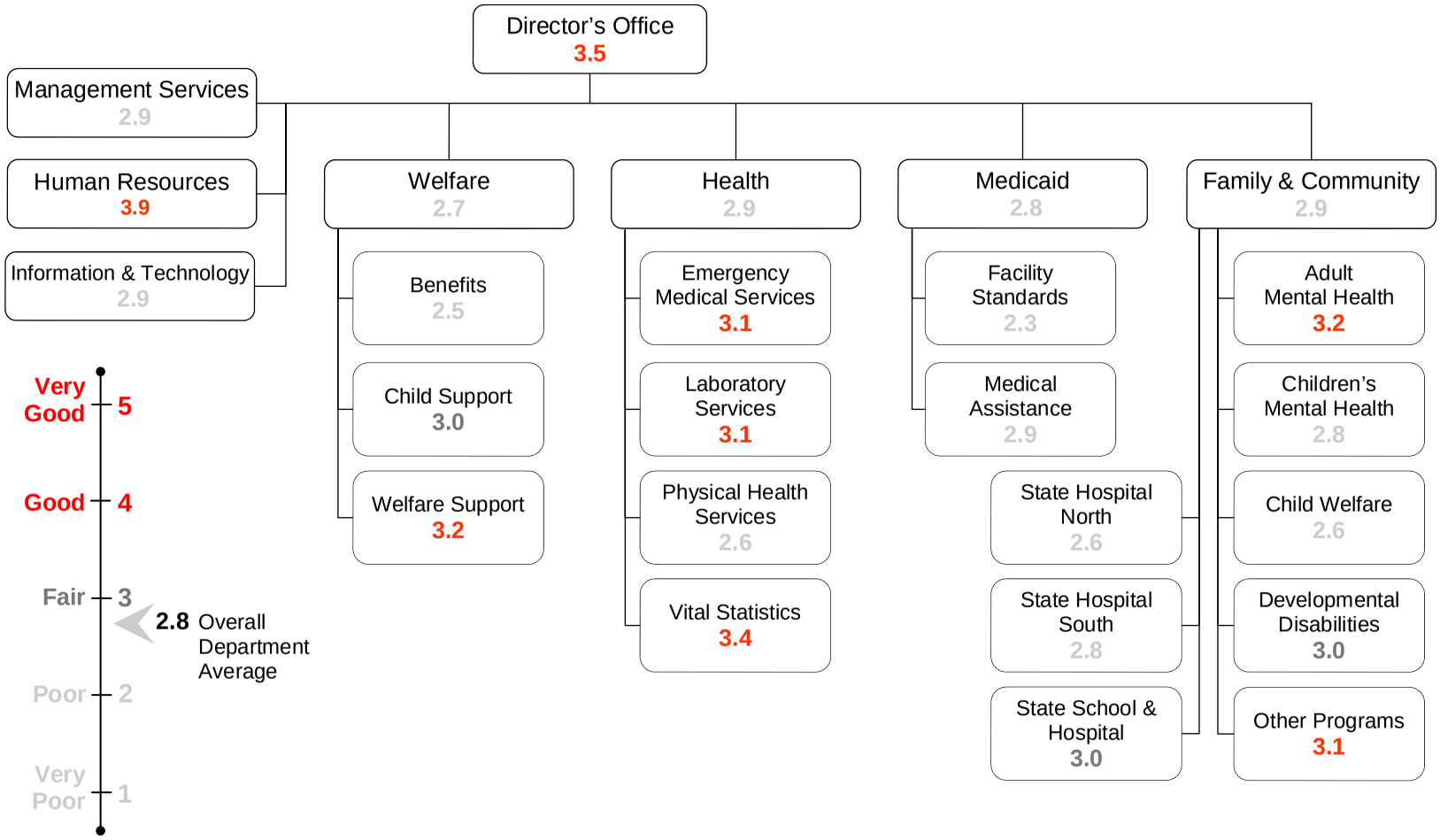
	Good or Very Good	Fair	Poor or Very Poor	Average Rating[a]
Family and Community Services	34.2%	27.5%	38.3%	2.9
Health	38.2	28.5	33.4	2.9
Medicaid	28.1	35.4	36.4	2.8
Welfare	28.8	26.4	44.8	2.7
Indirect Support Services	38.6	28.1	33.4	3.0

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Exhibit 3.2: Responses of Staff and Supervisors on Workplace Morale, by Division and Program



Note: Levels of staff and supervisors' agreement with: "Overall, workplace morale among my co-workers is," on a scale of 1 to 5, where 5 is very good and 1 is very poor.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

these areas, more than half of those responding to the survey rated co-worker morale as good or very good.

Morale ratings were lowest in Benefits, Facility Standards, Physical Health Services, and at State Hospital North. In each of these areas, a majority of staff responding to the survey rated morale among their co-workers as poor or very poor. Morale ratings were also low in Child Welfare, Children's Mental Health, Information and Technology Services, Medical Assistance Services, and at State Hospital South. In each of these areas, more staff rated morale as poor or very poor than rated it as good or very good.

Pay, Stress, and Workload Were the Most Commonly Cited Factors Impacting Workplace Morale

As part of the survey, staff were asked to identify the factors that have the greatest *negative* impact on morale among their co-workers. Pay was the most commonly cited factor, mentioned by nearly two-thirds of staff and supervisors responding to the survey (64.1 percent). More than a third of all staff and frontline supervisors responding to the survey (36.4 percent) ranked pay as the factor that had the greatest negative effect on morale.

The level of stress at work and staff workload were the next most commonly cited factors negatively impacting staff morale. Work-related stress was cited by 53 percent of all staff and supervisors responding to the survey, and workload was mentioned by 45 percent. Other factors frequently mentioned as contributing to low morale included management and the level of legislative support.

Employees Generally Reported Satisfaction with Their Jobs

Although ratings of workplace morale were mixed, most staff reported they were satisfied with their jobs.[1]

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[1] The finding that job satisfaction ratings among the respondents were relatively high, whereas the morale ratings from the same respondents were relatively low, may on the surface appear contradictory. However, the two constructs are considered to be quite different, at least in the organizational literature. Job satisfaction is a complex and multidimensional construct, encompassing an employee's satisfaction with specific job characteristics, workplace environment, schedule, sense of purpose, and perception of making a difference. Morale encompasses the feelings employees have about whether they "fit" or belong in an organization, whether they are valued in that organization, and whether they have positive overall impressions of the organization and how employees within it are treated. Thus, it is quite possible that respondents could have high job satisfaction but poor morale.

Overall, 65.5 percent of staff and supervisors agreed or strongly agreed with the statement "In general, I am satisfied with my job." In contrast, less than 20 percent of staff and supervisors reported they were not satisfied. Job satisfaction ratings were even higher among middle managers, with 75.3 percent reporting they were generally satisfied with their jobs.

Job satisfaction ratings were positive throughout the department, with a majority of staff in most program areas indicating they were generally satisfied with their jobs. Staff in Physical Health Services reported the lowest job satisfaction, with 46.8 percent of staff indicating they were satisfied with their job. Job satisfaction ratings also appeared to be relatively low in Benefits and Facilities Standards.

Potential Areas for Further Study

We identified five program areas with relatively low workplace morale. These programs may warrant more in-depth review to analyze the causes for low morale ratings:

- Benefits, Division of Welfare
- Facility Standards, Division of Medicaid
- Child Welfare, Division of Family and Community Services
- Physical Health Services, Division of Health
- State Hospital North in Orofino

Chapter 4
Communication

Ratings of the quality of communication within the Department of Health and Welfare were fair overall, but varied by level of employee and program. Staff and supervisors were slightly more critical than managers, and central office managers were decidedly more positive than managers working in the field. Both staff and managers indicated they had better communication with their immediate co-workers or within their program area than with upper management. Nearly half of staff indicated the atmosphere in their program did not promote openness and candidness, and fear of retaliation from management was an issue for many.

In the absence of an integrated vision for communication within the department as a whole, individual Health and Welfare divisions facilitate communication in different ways, reflecting their varied operational and organizational structures.

Communication Needs an Integrated Vision

For agencies as large as the Department of Health and Welfare, effective communication with staff and the public is important. The quality of communication can affect program accountability and effectiveness, and other crucial functions of the organization. The Government Accountability Office (GAO), in a study of a federal commission, found that improved communication and coordination between management and employee representatives "could reduce potential conflict and enhance resolutions."[1] According to GAO, communicating a clear message is one of the ten best principles of human resource management, which links staff efforts to agency outcomes.[2] In its strategic plan for 2005 to 2008, the Department of Health and Welfare recognized that better communication creates a shared department vision and improves the quality of services provided to Idaho citizens.[3]

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1 Government Accountability Office, *Securities and Exchange Commission: Human Capital Challenges Require Management Attention* (September 2001), 27.

2 Government Accountability Office, *Human Capital: Key Principles from Nine Private Sector Organizations* (January 2000), 11.

3 Department of Health and Welfare, *Strategic Plan '05–'08*: *Goal Five* (2002).

In May 2002, the Department of Health and Welfare entered into a significant realignment process that aimed to improve customer service by improving communication between those who develop and those who implement policy. Previously, a strategic communication document developed in 2000 identified a number of potential practical improvements to the department's communication structures, including an internal communications plan and staff feedback mechanisms (e.g., brown bag lunches or online chat sessions with managers).[4] Department officials report these and other proposed changes were not implemented due to budget cuts that affected communications staffing.

Communication plans have been developed for distinct projects, such as the Service Integration-Any Door initiative, or functions, such as emergency preparedness under the Division of Health. Because the department has not implemented an integrated plan for communication, communication within the department relies to a great extent on processes established by each division, and the interactions of managers and staff within and between divisions.

Communication Structures Varied by Division

Through interviews with all seven division administrators, we determined that division staff-management communication is largely driven by program functions or authority structures rather than a systematic model for the organization. Reflecting the diverse structures of the department at the division level, each division or institution employs various formal and informal means as well as direct and indirect means to communicate within the organization:

- **Meetings, conference calls.** Divisions use meetings and telephone conferences extensively as a means of communicating with staff. For some, this is the primary means for sharing information between staff and management. Participation in and frequency of meetings are based on particular functions or specific aims within divisions. For example, meetings are used by the director's office as a primary means of communication within upper management; the director's office communicates with department staff primarily through *InfoNet.*

- ***InfoNet.*** The department's internal computer network, *InfoNet*, allows department and division management to communicate both static and interactive information to employees, and offers staff limited opportunities to provide feedback to management. Division polices are widely available on *InfoNet*, and interactive portals—*SharePoints*—may be used to coordinate the staff input on policy development, as in the Division of Medicaid. *Headline News*, a feature of *InfoNet*, is the only official feedback mechanism for all department staff. Online response

[4] Department of Health and Welfare, *Strategic Communications Plan* (June 2000), 17–18.

forms at the end of each news story allow staff to comment. Anonymous comments are not accepted and, although communications staff aim informally to safeguard the identity of respondents if requested, this is not supported by written policy.[5]

- **Policy development processes.** Policy development affords an opportunity for management to respond to the experience of staff, and for staff to affect the direction of their organization. Circulation of policies is also an important tool for ensuring clarity on roles, responsibilities, and collective goals. The divisions of Welfare, Medicaid, Family and Community Services, and Information and Technology Services have instituted policy development structures to allow, and in some cases encourage, staff involvement.

- **Employee grievance resolution process.** The department's process is structured in compliance with Idaho Code and Administrative Rules, and encourages employees to speak to supervisors before requesting formal mediation.[6] Each division or institution administrator is responsible for the outcome of the process. Department and division management report encouraging an open-door policy facilitated by travel to the regions. In lieu of department-wide informal resolution alternatives, a formal grievance process is available to *redress* appropriate communication between line staff and management.

Opinions on Overall Communication Were Fair

Overall, 41.8 percent of staff and supervisors responding to our survey rated communications within the department as fair (the middle value on a five-point scale), while 34.2 percent said poor or very poor and less than one quarter (23.9 percent) said good or very good. Aside from State Hospital North, where 54.8 percent of staff rated overall department communication as poor or very poor, staff opinion did not vary widely by location.

Middle managers gave slightly more positive ratings to communications within the department, with 36.9 percent rating communication as fair, and 27.7 percent as poor or very poor. As shown in exhibit 4.1, managers at the three institutions operated by the department were most inclined to rate overall department communication as poor or very poor (40.0 percent), and fair (44.0 percent). Just 16 percent of this group had a positive view. Conversely, 42.2 percent of managers at the central office found communication to be good or very good.

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[5] Department of Health and Welfare, *Headline News Reader Response Policy*.

[6] IDAHO CODE §§ 67-5309, -5315; IDAPA 15.04.01.200, .273; Department of Health and Welfare Policy Manual, Section 20A, *Departmental Problem Solving.*

Exhibit 4.1: Staff, Supervisor, and Manager Ratings of Overall Communication in the Department, by Division and Location

Staff and Supervisors: "Overall, communication within the Department of Health and Welfare is:"

	Good or Very Good	Fair	Poor or Very Poor	Average Rating[a]
Family & Community Services	23.8%	42.1%	34.2%	2.8
Health	34.5	35.3	30.2	3.0
Medicaid	16.3	47.9	35.8	2.7
Welfare	25.1	41.6	33.3	2.8
Human Resources	53.3	46.7	0.0	3.7
Information and Technology	20.2	32.3	47.5	2.6
Management Services	20.3	44.4	35.4	2.7
Director's Office	27.3	54.5	18.2	3.1

Middle Managers: "Overall, communication within the Department of Health and Welfare is:"

	Good or Very Good	Fair	Poor or Very Poor	Average Rating[a]
Central Office	42.2%	31.3%	26.6%	3.1
Institutions	16.0	44.0	40.0	2.7
Regional offices	36.6	40.4	23.1	3.1

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff, supervisors, and middle managers, November 2005.

Communication with Co-workers and Frontline Supervisors

The outlook of staff and supervisors was generally positive when asked to rate the quality of communication with co-workers and immediate supervisors or within their program area. A clear majority of staff indicated that communication with their co-workers (70.0 percent) and immediate supervisors (68.9 percent) was good or very good.

As shown in exhibit 4.2, a clear majority of staff and supervisors in every division agreed that their supervisor kept them informed of their responsibilities. A majority in each division also said their immediate supervisors encouraged staff to express suggestions or complaints, and then listened to staff recommendations.

Exhibit 4.2: Staff and Supervisor Ratings of Job Information Provided by Supervisors, by Division

"My supervisor lets me know exactly what is expected of me."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Family & Community Services	71.1%	15.4%	13.6%	3.8
Health	69.1	13.0	17.9	3.7
Medicaid	65.8	15.0	19.2	3.7
Welfare	68.8	16.0	15.2	3.7
Human Resources	100.0	0.0	0.0	4.5
Information Technology	67.0	20.0	13.0	3.8
Management Services	73.7	15.2	11.1	3.8
Director's Office	90.9	9.1	0.0	4.3

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Communication with Management

Staff confidence in communication with their program managers and with upper management, however, is at best mixed, and is generally lower compared to the level of confidence shown in frontline supervisors. Almost one-third (32.9 percent) of staff and supervisors disagreed or strongly disagreed with the statement: "I receive enough information from top management to do my job well." A similar proportion (32.1 percent) neither agreed nor disagreed with the statement. These two groups taken together may suggest a disconnect between upper management and staff.

Communication with Legislature

About 80 percent of department managers felt legislators did not have a good understanding of the required functions or resource needs of their programs, and 45.6% said the Legislature was not adequately informed about program effectiveness through the department's performance measures. These perceptions indicate that communication between the department and Legislature should be examined more closely to determine what improvements may be needed.

Managers were divided about the quality of communication between their program and upper management, with 42.9 percent indicating it was good or very good, and 30.7 percent poor or very poor. As shown in exhibit 4.3, only 7.1 percent of managers in the Division of Welfare

Exhibit 4.3: Middle Manager Ratings of Communication from Upper Management, by Division

"Communication from upper-level to my program is:"

	Good or Very Good	Fair	Poor or Very Poor	Average Rating[a]
Family & Community Services	45.3%	17.2%	37.5%	3.0
Health	40.0	28.0	32.0	3.0
Medicaid	42.1	31.6	26.4	3.3
Welfare	42.8	50.0	7.1	3.4
Indirect support services	38.9	33.3	27.8	3.1

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare middle managers, November 2005.

were critical of communication between programs and upper management. Managers in Family and Community Services were divided; 45.3 percent (more than any other division) rated this communication as good or very good and 37.5 percent (more than any other division) rated this communication as poor or very poor.

Value of Staff Input

Less than half (44.4 percent) of staff and supervisors overall felt program managers valued their suggestions (see exhibit 4.4). By division, the proportion of respondents who agreed ranged from 35.6 percent in Welfare and 55.1 percent in Health, to 81.3 percent in Human Resources. The Division of Welfare also illustrates how programs within an organization may vary. In Benefits, nearly half (46.8 percent) of staff responding felt program managers did *not* listen to their recommendations, compared to 30.1 percent who felt they did. In the Child Support program, these proportions were reversed, with 27.2 percent reporting their program managers did *not* consider their suggestions, and 44.7 percent reporting they did.

More than two-thirds of middle managers in all divisions (68.5 percent) indicated their input is valued by the next higher level of management.

However, the opinions of staff and supervisors when asked if upper management listened to their recommendations were less positive, with 48.6 percent of staff and supervisors responding that upper management did not listen to their recommendations. Responses also varied dramatically by division. While 75

Exhibit 4.4: Staff, Supervisors, and Managers on the Value Placed on Their Opinions and Suggestions

Staff and Supervisors: "The following managers listen to the recommendations of staff."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Upper management	20.3%	31.1%	48.6%	2.5
Program managers	44.4	22.3	33.3	3.1
Frontline supervisors	66.9	16.2	17.0	3.7

Middle Managers: "My input is valued at the next higher level of management."

Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
68.5%	13.6%	17.9%	3.7

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff, supervisors, and middle managers, November 2005.

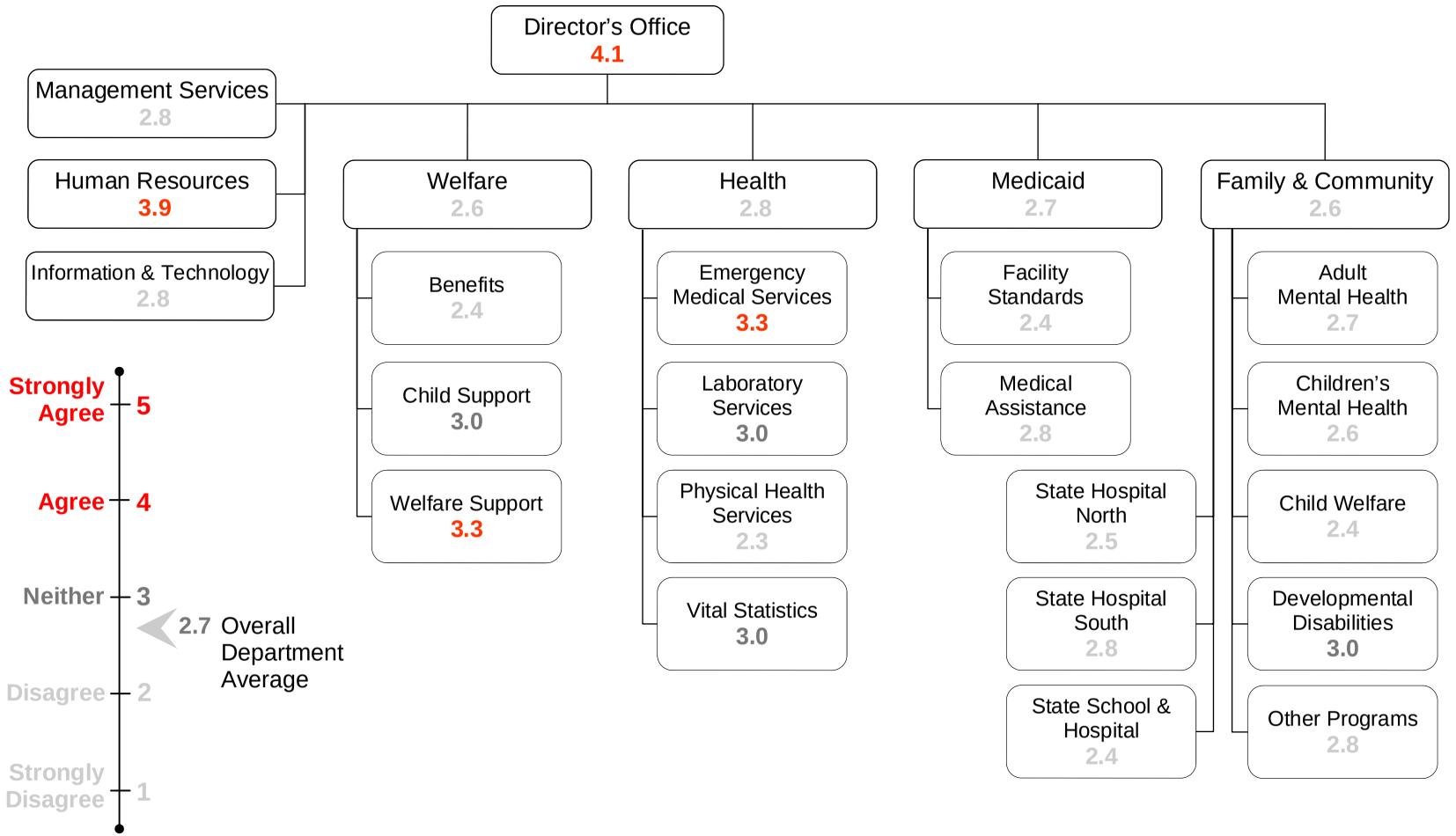
percent of Human Resources staff agreed that upper management listened to their recommendations, the proportion of staff in the remaining divisions who agreed was minimal in comparison, ranging from 16.3 percent (in Family and Community Services) to 33.3 percent (in the director's office).

Many Staff Feared Retaliation When Communicating with Management

Just 31.3 percent of staff responding to our survey agreed with the statement "The atmosphere in my program encourages people to be open and candid with upper management." In contrast, nearly half of respondents (48.4 percent) disagreed, with over half of those (24.8 percent of the total) disagreeing strongly.

As shown in exhibit 4.5, there were also significant variations among programs. While 72.8 percent of staff in the director's office and 62.5 percent in Human Resources felt the atmosphere at their program level encouraged openness, in the other divisions the proportion of staff who felt the program atmosphere encouraged openness ranged from only 28.5 percent (in Family and Community Services) to 37.1 percent (in Management Services).

Exhibit 4.5: Responses of Staff and Supervisors on Candidness and Openness of Program Atmosphere, by Division and Program



Note: Levels of staff and supervisors' agreement with: "The atmosphere in my program encourages people to be open and candid with management," where 5 is strongly agree and 1 is strongly disagree.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Exhibit 4.6: Staff, Supervisors, and Managers on the Ability to Talk Openly Without Fear of Retaliation

Staff and Supervisors: "I can talk openly with the following managers about work-related problems without fear of retaliation."

	Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
Upper management	23.8%	28.0%	48.3%	2.6
Program managers	48.3	17.8	33.8	3.1
Frontline supervisors	69.2	12.5	18.3	3.7

Middle Managers: "Employees may talk openly about work-related problems without fear of retaliation from management."

Agree or Strongly Agree	Neither Agree nor Disagree	Disagree or Strongly Disagree	Average Rating[a]
51.4%	19.3%	29.3%	3.2

Note: Percents may not sum to 100 due to rounding.

[a] Based on a 5-point scale where 5 is the most positive rating.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff, supervisors, and middle managers, November 2005.

More than two-thirds of staff responding to our survey (69.2 percent) believed they could approach their frontline supervisors about work-related problems without fear of retaliation (see exhibit 4.6). Staff in the Division of Human Resources were the most optimistic (93.3 percent) on this point. In contrast, 50 percent of staff in the Office of the Director reported they could *not* talk openly with frontline supervisors. Of staff in the remaining divisions, those who indicated they *could* talk openly with frontline supervisors ranged from 61.1 percent in Welfare to 79.6 percent in Management Services.

Overall, many staff and supervisors were less optimistic about their ability to talk with management without fear of retaliation. Nearly half (48.3 percent) of all respondents felt they were *not* able to speak to upper management about work-related problems without fear of retaliation; fewer than one quarter (23.8 percent) indicated they could speak with upper management without fear of retaliation. Conversely, nearly half (48.3 percent) of staff indicated they did not fear retaliation when discussing work-related issues with *program managers*. However, one-third (33.8 percent) felt retaliation could result from discussions with program managers.

Resolution Process

Health and Welfare Human Resources policy states that "*no* supervisor or any other official…*may* retaliate against an employee" for participating or assisting others participating in the employee grievance resolution process.[7] In spite of this policy, survey responses on whether discussing problems with management would lead to retaliation and on the fairness and equity of the problem-solving process suggest some employees' concerns have not been eased. This survey response is crucial because, according to department policy, staff should first discuss grievances with supervisors before entering the formal resolution process.

Overall, one-third of staff (33.3 percent) neither agreed nor disagreed with the statement "the problem-solving (grievance) process is fair and equitable to all employees," while 39.7 percent disagreed and 27 percent agreed. These responses show a wide degree of variation by program (see exhibit 4.7). All Human Resources staff (100 percent) who responded to our survey agreed or strongly agreed that the problem-solving (grievance) process was fair and equitable. However, the views held by staff in the other divisions were very different.[8]

Less than one-third (32.6 percent) of staff in the Division of Health expressed confidence in the grievance process. About 72 percent of staff in the director's office indicated the process was *not* fair or equitable. Among the remaining divisions, from 38.7 percent (in Welfare) to 42.2 percent (in the Information and Technology Services Division) also felt the process was inequitable. In addition, we received comments from seven employees who expressed dissatisfaction with the degree of attention the Division of Human Resources paid to such matters.

Department records indicate that five formal grievance proceedings were initiated in 2004, and ten in 2005. Most of these cases involved the two largest divisions, Welfare and Family and Community Services. Of Welfare's four cases, one case implemented the employee's proposed resolution, one case was resolved through a compromise on employee demands, and alternate solutions were found for two cases. In all five of the cases occurring in the Division of Family and Community Services, including one at the State Hospital North and two at the Idaho State School and Hospital, employees' proposed resolutions were denied by management.

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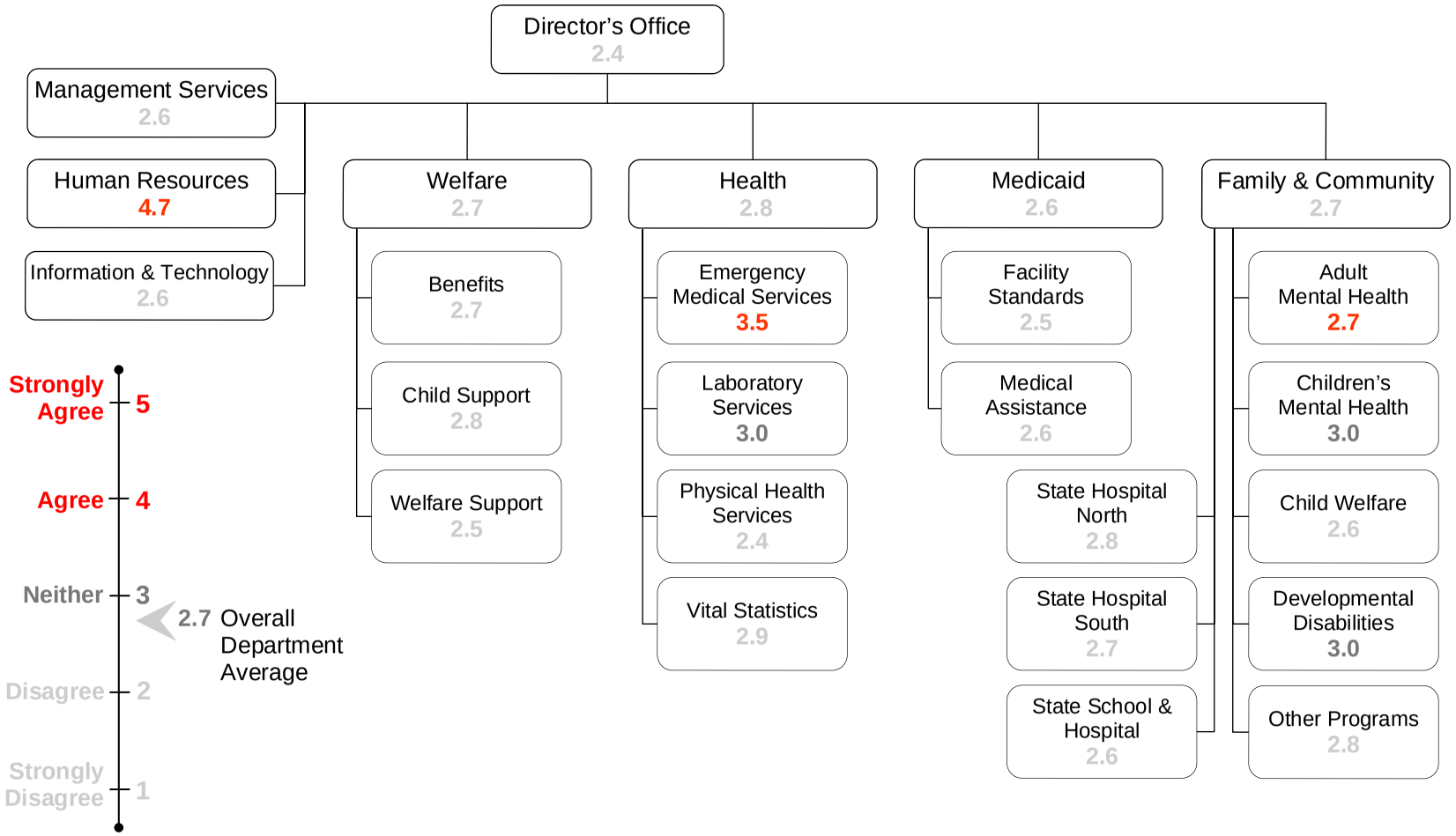
[7] Department of Health and Welfare Policy Manual, Section 20A, *Departmental Problem Solving.*

[8] In line with its supportive and guidance role, Human Resources has promulgated the policies guiding the department's employee grievance process, but has no direct authority over the process. Each division or institution administrator is responsible for the outcome.

Exhibit 4.7: Responses of Staff and Supervisors on the Fairness and Equity of the Employee Grievance Process, by Division and Program



Note: Levels of staff and supervisors' agreement with: "The problem-solving (grievance) process is fair and equitable to all employees," where 5 is strongly agree and 1 is strongly disagree.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Recommendation

4.1: The Department of Health and Welfare should:

a. Examine the causes for employees' lack of confidence when communicating with management.

b. Take steps to address these concerns and build two-way communication between staff and management by examining structures and policy language of the employee grievance resolution process, and encouraging intermediate and informal alternatives for staff.

Potential Areas for Further Study

Staff concerns about issues relating to intradepartmental communication were greatest in the following program areas, indicating that these areas may benefit from in-depth review:

- Idaho State School and Hospital in Nampa
- Physical Health Services, Division of Health
- State Hospital North in Orofino
- Child Welfare, Division of Family and Community Services
- Benefits, Division of Welfare
- Facility Standards, Division of Medicaid

Chapter 5
Staffing and Workload Analysis

One of the key responsibilities of management is to ensure that it makes the most cost-effective use of its staffing resources. We found that several major program areas in the Department of Health and Welfare do not currently employ well-developed workload models to assist in making staffing decisions. These programs have methods in place that are limited in their ability to assess staffing needs, to identify the most cost-effective work processes, and to allow the department to react optimally to changes in funding levels. We also found that managers of the state's three inpatient institutions have questions about how to achieve efficient staffing and scheduling, but do not have the necessary data and analytical resources to address this issue.

The department has recently begun leveraging the experience of its Division of Welfare in developing more systematic approaches to staffing analysis. The department should continue to draw upon this experience, and further expand its efforts to bring more effective methods to other programs. The department should also build new analytical capabilities to assist the three inpatient institutions with resource utilization, and evaluate a potential workload imbalance issue in the Division of Welfare that we identified in our survey of line staff and supervisors.

Staffing and Workload Models Can Help Management Make Cost-Effective Decisions

Managing workload and using staffing resources effectively are key management responsibilities. The use of empirical analyses, caseload standards, workload models, and other systematic approaches can be of value for analyzing staffing needs and for managing programs. In addition to cost considerations, how an agency manages staffing levels and allocates staff can affect morale and turnover, as well as the levels and quality of services to clients.

Empirical analyses rely on the collection of a large amount of data for testing hypotheses and drawing conclusions. The results of such analyses can be verified by repeating the method or by using statistical tests to estimate a confidence level.

Well-developed staffing and workload models can be used for:

- Identifying, in a systematic way, key workload and caseload activities and processes

- Establishing internal benchmarks for efficient operations within an agency or program
- Estimating needed staffing in relation to changes in workload and caseload
- Identifying process changes that can have the least impact on service delivery (especially valuable when budget holdbacks are necessary and estimated staffing needs cannot be funded)
- Understanding how work processes and staffing levels affect performance

The use of staffing and workload models is particularly important for a large agency such as the Department of Health and Welfare, which represents approximately 18 percent of the state government workforce. The effectiveness of the department's management of such a large number of staff can influence citizens' overall satisfaction with the services delivered by state government.

Our surveys of department employees highlight the need for effective workload monitoring and staffing needs assessment.

- 49 percent of staff and supervisors reported that they generally do not have enough time to do the work assigned to them
- 67 percent of staff and supervisors, and 65 percent of middle managers, said their programs did not have a sufficient number of staff to carry out program responsibilities
- Survey respondents identified workload as one of the key factors that negatively impacts employee morale and contributes most to turnover within the agency

Study Approach

The major focus of this evaluation was to inventory and review the department's methods for analyzing caseloads, workloads, and staffing needs. We wanted to learn if the methods are useful management tools, and whether the information provided to the Legislature is useful in making budget decisions.

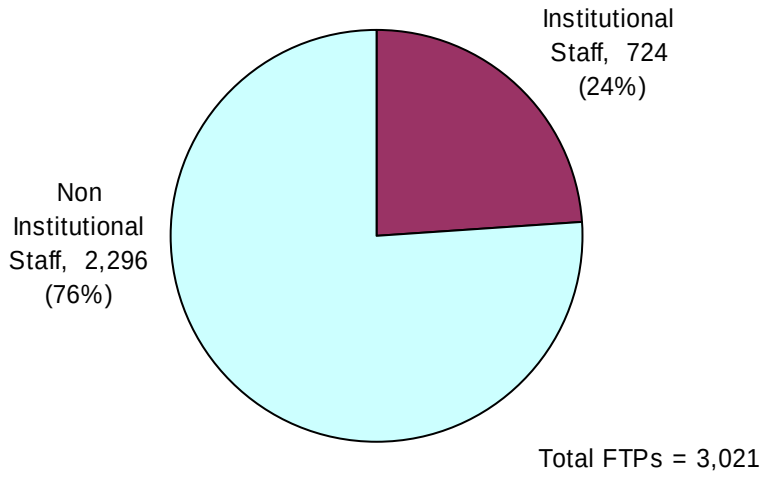
In this chapter we discuss staffing and workload analysis within the department by first breaking down the staffing into two categories: non-institutional staff (those working in various department programs *outside* state hospitals) and institutional staff (those working *in* state hospitals). As exhibit 5.1 shows, institutional staff account for almost one-fourth of all staff in the department. Institutional staffing is displayed and discussed separately in this chapter, because the three state institutions (Idaho School and State Hospital, State

Hospital North and State Hospital South) each face similar challenges in relation to staffing that are different from the challenges confronting other department programs.

Staffing Methodologies and Models Vary for Non-Institutional Programs

Based on the information provided by the department, its programs use, or are in the process of developing, some kind of staffing and workload analysis, standard, or formula for about two-thirds (69 percent) of non-institutional staff. Not surprisingly, the largest categories of staff currently subject to some kind of staffing methodology are in programs where staff have the same or similar duties, and/or who serve similar clients. As will be discussed in more detail later, the staffing methodologies employed by the department vary greatly in terms of usefulness to decision-makers. They range from being well-developed management tools to simple formulas that allocate staff to regions based on the populations of the regions.

Exhibit 5.1: Institutional and Non-Institutional Full-Time Positions in the Department of Health and Welfare, Fiscal Year 2006



Note: FTPs do not sum due to rounding.

Source: Office of Performance Evaluations' analysis of data from Legislative Budget and Policy Analysis, *Idaho Legislative Budget Book for Fiscal Year 2006*.

The remaining 31 percent of staff, according to the department, are not subject to a workload analysis, standard or formula. For the most part, these staff do not provide services directly to the public, but instead perform administrative and support functions.[1]

Having said that, we do not want to leave the impression that decision-making about programs and staff falling within the 31 percent is done in the absence of analysis. To the contrary, some of these areas have been scrutinized during the budget process, as seen in the following examples:

- With legislative approval, the department began in fiscal year 2006 the first phase of converting contracted Information and Technology staff into 41 full-time positions in order to effect savings.

- For fiscal year 2006, the Legislature approved the addition of three staff to Estate Recovery within Medical Assistance (and one attorney in the Attorney General's Office) to identify and process more cases for recovery. Estimates by the department indicate that revenue from increased recoveries may be even higher than was projected.

In the next sections of this chapter, we focus on the six largest, non-institutional program areas that rely on or are developing some kind of staffing and workload analysis or standard. A review of these areas provides an overview of the status of the department's use of staffing and workload models, and identifies areas of strengths and weaknesses. Exhibit 5.2 provides a summary of the current use, or absence, of methods for assessing staffing needs in each of the program areas we evaluated.

Division of Welfare's Workload Model Uses Random Moment Sampling

The Division of Welfare, which is responsible for the benefits and child support programs, has an empirically based and well-developed method for assessing workload and estimating staffing needs. The workload model called the Resource Utilization Model was first developed in 2001 as part of a nine-month resource utilization study. A management consulting firm, Sterling Associates, used a random moment sampling to identify the amount of time staff spent on key activities

Random moment sampling is a method for obtaining a measurement of how much time staff spend on certain activities related to cases. It relies on staff to report their activities when prompted by a pager at randomly occurring times. Because the sample size can be large, there can be a high level of confidence in the accuracy of the measurements.

[1] Nevertheless, there may still be some programmatic areas and staff within the 31 percent that can or should be subject to a workload analysis or standard. Time limitations of this study prevented us from evaluating every program and subprogram in detail, and therefore the 31 percent could be overstated.

Exhibit 5.2: Overview of Staffing Review Methods Used in Six Major Non-Institutional Program Areas in the Department of Health and Welfare

	Division of Welfare Programs	Child Welfare and Children's Mental Health	Medicaid Services	Community Mental Health	Developmental Disabilities	Facility Standards
Full-time positions	512	438	112	232	152	48
Well-developed work/caseload model in place	✔					
Well-developed work/caseload model in development		✔				
Staffing model of limited utility or not applicable to all program staff			✔			✔
Staffing allocated to regions by formula, not on analysis				✔	✔	
Staffing based on historical levels, not on analysis			✔			✔

Source: Office of Performance Evaluations' analysis of the Department of Health and Welfare information.

associated with the cases they handled during their workdays. Altogether, the study collected 74,000 random moment samples. The consultants also developed process maps of the various case-handling activities of the division's regional offices.

Since 2001, the Division of Welfare has updated and modified its model three times to reflect changes in caseload that have necessitated revisions in work processes. The division is now in the process of creating a fourth version. According to the division, costs for the initial study and its first update, both of which relied on outside consulting assistance, totaled approximately $650,000. Subsequent updates have relied less on consultants and more on in-house staff.

Welfare's Model Is Overcoming Potential Weaknesses

The Division of Welfare's Resource Utilization Model is versatile and has helped the division respond to growing caseloads and staffing decreases. However, there were initially some potential weaknesses. The sampling methodology measured only the time it took staff to do their work. It did not address whether the work should be done, or whether it was being performed efficiently and effectively.

Based on our review of the model, a history of its use, and a demonstration by division staff, it appears to have overcome, or is overcoming, the limitations that such a model may present. As examples:

- Workload standards developed during the initial study have been modified to reflect necessary changes in work processes to accommodate more cases handled by fewer staff. This change has been particularly important over the last several years with increasing caseloads and fewer staff, due to budget holdbacks.
- The process mapping done as part of the initial study has helped to identify efficient processes within some offices that have served as benchmarks for other offices.
- The Division of Welfare is attempting to tie workload measurements to performance. For example, the division wants to see how inequalities in staffing among regional offices affect the food stamp error rate and errors in enrollment.
- Because imbalances in workload among offices occur, some steps must be taken to allocate staffing equitably. However, the model is not currently used as a basis for making transfers of staff among offices; but instead, it is used to help decide which offices can fill vacancies and which offices must realize the effects of layoffs. Department officials have indicated there are enough vacancies and turnover in staff that the department can address imbalances without resorting to transferring employees from one office to another.

Estimates of Staffing Needs and Budget Realities

The situation facing the Division of Welfare illustrates a challenge that occurs when budget realities conflict with model projections of staffing need. We found the Division of Welfare has a well-developed model. Nevertheless, based on our survey of staff and supervisors, perceptions of problems with staffing and workload within Welfare tend to be more prevalent, by almost all measures, than in other divisions or programs.

For instance, as shown in exhibit 5.3, more staff and supervisors in Welfare programs (more than in most other programs in the department) said they did not have enough time to do their assigned work. The same trend appeared when staff and supervisors were asked if staffing in their unit was sufficient to carry out the unit's responsibilities. Additionally, over half of Division of Welfare staff and supervisors said their program or unit did not have sufficiently qualified staff.

Based on the historical caseload and staffing information provided by the Division of Welfare, these survey results may come as no surprise. Because the division's programs have some of the largest numbers of full-time positions within the department, it is a practical reality they may sustain relatively large staff reductions in times of budget holdbacks. For instance, the department pointed out that it has fewer positions now than in 2002, while the demand for most services over these years has increased. From 2001 to 2004, the division estimates its caseload increased by 14 percent. Meanwhile, staffing in the division fell from 709 in 2001, to 550 in 2004, and is now at 600.

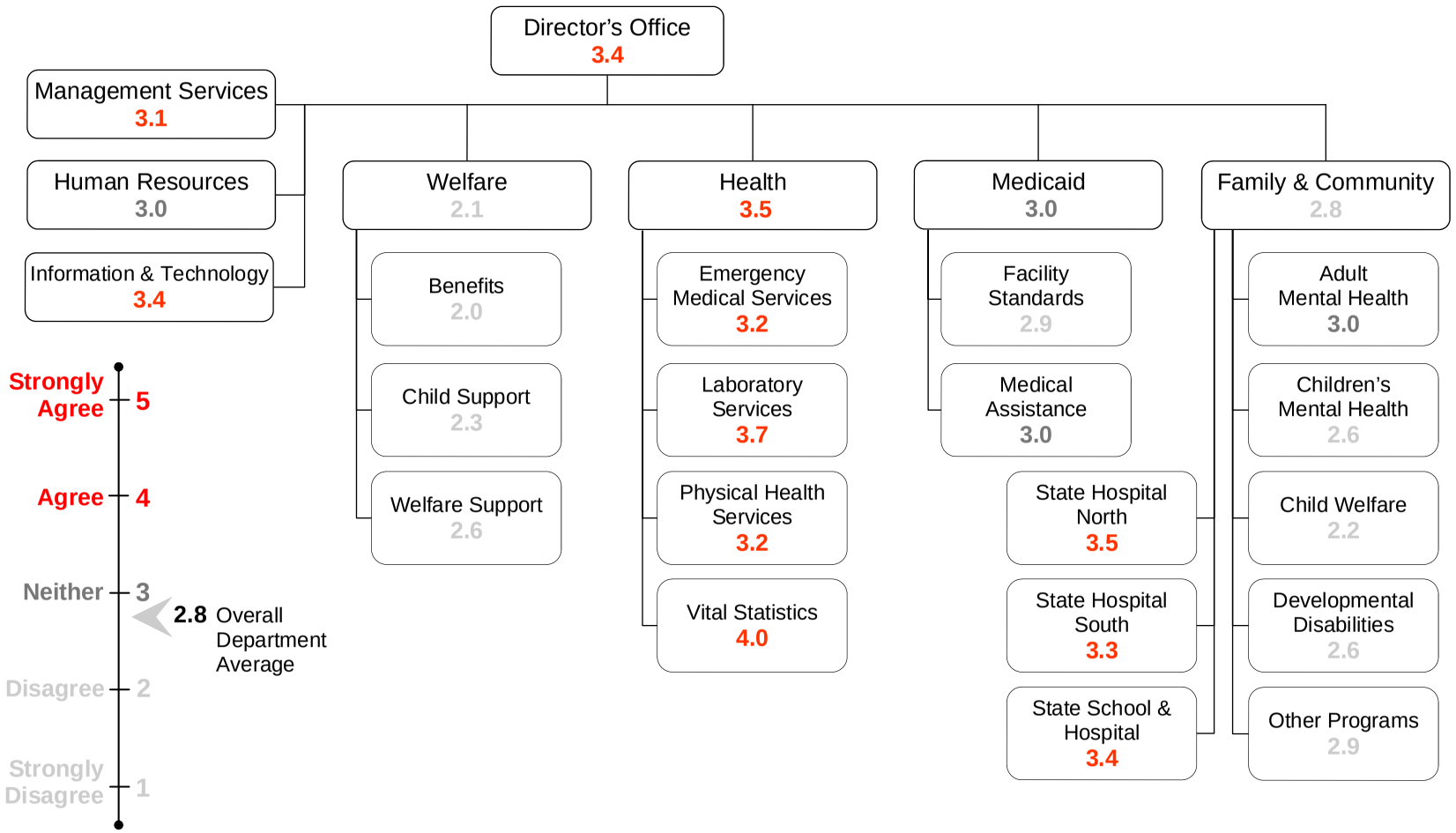
According to Resource Utilization Model estimates, the deficit in the division's staffing is currently about 170 full-time positions. Partly in response to budget holdbacks requiring staffing reductions, and partly out of management efforts to increase efficiency, some of the workload standards derived by use of the model have been modified to reflect the adoption of better work processes to accommodate more cases and more workload to be handled by fewer staff.

Use of the Model

In spite of having a well-developed model, a surprising observation from our survey of staff and supervisors was that many of the staff in the Division of Welfare, particularly those in Benefits, perceived that the division has not managed its workload well, at least in terms of upper management making adjustments to workload as necessary. As previously mentioned, the division's model allows management to identify opportunities to adjust work processes and to know where and when workload imbalances occur among regional offices. However, staffing allocations do not necessarily follow what the model may suggest. Model outputs are considered, and are used to inform decisions, but are not the sole basis for making staff allocations.

As described by the division, the model is not currently used as a basis for making transfers of staff among offices, but instead, it is used to help decide

Exhibit 5.3: Responses of Staff and Supervisors on Having Enough Time to Complete Their Assigned Work, by Division and Program



Note: Levels of staff and supervisors' agreement with: "I generally have enough time to do the work assigned to me," where 5 is strongly agree and 1 is strongly disagree.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

which offices can fill vacancies and which offices must realize the effects of layoffs. Thus, staff concerns about workload imbalances might not be a matter of how well the model works, but could be an issue with how information from the model is used. It is understandable that the division might want to avoid transferring staff; but it is also of concern that staff perceive there to be workload imbalances. This is a subject that should be further reviewed by the division management.

Family and Community Services Is Currently Developing a Random Moment Study for Child Welfare and Children's Mental Health Programs

The Division of Family and Community Services has recently issued a Request for Proposals for a workload study in Child Welfare and Children's Mental Health programs. This study appears to be similar to the Division of Welfare's Resource Utilization Study.[2] This will be called the Workload Assessment Study and Staff Allocation Model.

Issues related to the existing caseload and staffing within Child Welfare were recently the subject of our evaluation report: *Child Welfare Caseload Management*, released in February 2005. This evaluation found that inconsistent caseload information made it difficult for management to know if staffing resources were used efficiently and effectively. The issuance of the Request for Proposals was, in part, a response to the report.

The development of the Workload Assessment Study and Staff Allocation Model is expected to cost approximately $135,000, as compared to the $650,000 spent on the initial development and first update of the Resource Utilization Model. The cost is lower partly because the scope of work does not include process mapping. According to the Division of Family and Community Services, process mapping may be included as part of the work assigned to the senior analyst. As department staff gain more expertise and experience in conducting workload studies and retain the tools used in the development of models, we could expect less reliance on consultants and a more cost-effective use of existing staff.

[2] The Division of Family and Community Services consulted with the Division of Welfare when developing its Request for Proposals. The division included the staff who manage the Division of Welfare's model on its study steering committee, and it intends to hire a senior analyst who will eventually become the manager of the study, similar to the arrangement that exists in the Division of Welfare.

Division of Medicaid Acknowledges the Need for a More Rigorous Staffing Model

The Division of Medicaid indicated that caseload reporting across regions has always been a challenge. In July 2005, the division implemented the Regional Medical Assistance Services database. One of its purposes is to provide consistent tracking and reporting across regions.

The division last analyzed staff needs for its Medical Assistance Services in 2002. In an allocation study conducted that year, caseload data was gathered for the seven regions, and staffing needs were estimated based on work-time estimates for Region 6 nursing staff. This Region 6 staffing information was then applied to nursing staff in all regions to estimate overall staffing needs. Because it was applied only to nursing staff, the methodology was relevant for less than half of the total number of staff, and did not include Healthy Connections staff. There were other shortcomings in the methodology as well:

- Estimates based on Region 6 work activities were used as a surrogate for measures of actual time for activities in the other regions
- The approach implicitly assumed a linear relationship between staffing and caseload; that is, a percentage increase in caseload would require the same percentage increase in staffing
- Caseload tracking among regions has not been consistent

Program officials told us that a new methodology will be developed, although they did not have details about the planned approach.

Community (Adult) Mental Health and Developmental Disabilities Programs Allocate Staff to Regions Based on Formulae

Rather than relying on analysis, both Mental Health and Developmental Disabilities report allocating staff to regions based on formulae:

- Mental Health positions are allocated to regions based solely on total population (all people who live in the region, not just clients)
- Developmental Disabilities positions are allocated to regions based on an equal weighting of total population (all people who live in the region, not just clients), total children with developmental disabilities caseload, and total infant/toddler caseload

An exception to the allocation rule in Mental Health occurs when additional funds become available. For example, when additional Assertive Community Treatment staff were authorized, they were allocated based on assessments conducted by the regional mental health councils, and judgments about where they were needed most. In this instance, three of eight staff went to Region 2.

The lack of empirical methodologies in both programs also means the programs face difficult challenges in identifying and quantifying how staffing impacts clients—for example, when caseload is increasing but staffing remains static. Especially in the case of Mental Health, allocating staff based on regional population rather than the prevalence of eligible clients and/or of people needing services and the acuity of those people, can result in imbalances in services among regions.[3]

Both Mental Health and Developmental Disabilities can point to problems associated with caseload growth and a static staffing level. For example, according to the department, although the number of children served in Developmental Disabilities' Infant/Toddler program has grown by 29 percent in the last two years, there has been no increase in the number of staff in more than ten years. However, in their budget requests, neither program produced information tying specific staffing numbers to specific outcomes or consequences for the persons served.

Although making such a connection may be difficult, it is something that could be of major benefit. As mentioned, the Division of Welfare is attempting to tie workload measurements to performance. For example, the division wants to see how inequalities in staffing among regional offices affect the food stamp error rate and errors in enrollment. If successful, the Division of Welfare's experience could provide guidance for other programs.

This year, the Division of Family and Community Services began developing formal performance measures for Mental Health and Developmental Disabilities. We were told that Family and Community Services' intent is to develop enough useful information about caseload and performance that these programs can be subject to the same kind of approach that is planned for Child Welfare and Children's Mental Health.

Bureau of Facility Standards Relies on Prioritizing Work Efforts to Address Perceived Shortages

The Bureau of Facility Standards, within the Division of Medicaid, has responsibility for inspecting and licensing the state's health care facilities. The bureau shared with us an analysis it conducted for staff who inspect and respond to complaints involving residential and assisted living facilities. This analysis

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[3] A study for the state of Washington found that variations in regional funding, which were most strongly correlated to population, led to inequities in services. However, the same study also found the proportion of Medicaid-eligible persons is a good proxy for the estimated number of persons in need of public mental health services. State of Washington, Joint Legislative Audit and Review Committee, *Mental Health Systems Performance Audit* (December 13, 2000), 15–26.

was based on information for 2003 concerning how much time surveyors spent on-site for licensing, investigation, report writing and travel. The amount of time estimated for these activities was adjusted based on the size of the facility (for inspections), and on the priority of the complaint.

According to bureau management, the analysis suggests that 16 surveyors are needed, but they currently have only 10. They have responded by limiting report writing to the more significant licensing issues, and instituting other process changes. For the remaining staff in the bureau, we were informed that there has been no analysis for many years, that staffing has been static, but that workload has increased.[4]

State Hospitals Face Special Staffing Challenges

Idaho's three state inpatient institutions are the State Hospital North in Orofino, which serves acute, court-committed psychiatric patients; the Idaho State School and Hospital in Nampa, which serves severely impaired people with developmental disabilities; and the State Hospital South in Blackfoot, which provides psychiatric treatment and skilled nursing to adults and adolescents with serious mental illnesses. Together, these three institutions account for 24 percent of Department of Health and Welfare staffing. Staffing levels for the institutions are shown in exhibit 5.4.

Inpatient institutions face several challenges:

- Clients require service twenty-four hours a day, seven days a week. For the housing units where clients may spend most of their time, the institutions must set minimum staffing levels by shift for nurses, clinicians, and other staff who serve and protect these clients.[5]
- Institutions must have enough staff, and enough flexibility in how they use staff, to ensure there is an appropriate number of the right kind of staff where and when they are needed.
- Institutions need to ensure that operations are carried out efficiently, with the most cost-effective mix of full and part-time staff, and overtime.

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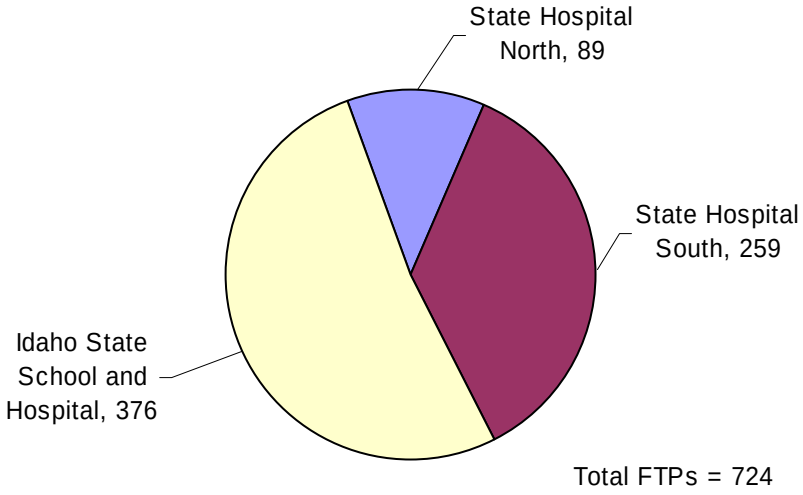
[4] The remaining staff do various jobs including determining eligibility for waiver clients, quality control, and consultations.

[5] Regulatory requirements specifically prescribe that hospitals have staffing plans, but the requirements do not specify the levels of staffing for each type of staff and each housing unit. In order for the state hospitals to comply with the requirements put forth from State Licensing, Medicare/Centers for Medicare and Medicaid Services, and the Joint Commission of Accreditation of Healthcare Organizations, they must set and maintain needed and appropriate levels of staffing across all patient care and support service areas.

Exhibit 5.4: Institutional Full-Time Positions in the Department of Health and Welfare, Fiscal Year 2006



Source: Office of Performance Evaluations' analysis of data from Legislative Budget and Policy Analysis, *Idaho Legislative Budget Book for Fiscal Year 2006*.

Institutions Lack Necessary Data or Analytical Tools to Address Staffing Issues

Based on our interviews with management at each of the three institutions, and site visits to the Idaho State School and Hospital and State Hospital South, we learned that none of the institutions currently track the information needed, nor do they have the analytical tools available, to ensure that they are managing their staff rosters in a cost-effective manner. According to the department, the last staffing study for all institutions was done about ten years ago. At that time, some staff planning was done, but positions based on the analysis were not appropriated and the analysis fell out of use.

Some of the specific problems mentioned in interviews and site visits included the following:

- There are cost implications of having temporary staff that work *more* than half time, but *less* than full time, and receive full employee benefits. Use of these staff gives the institutions some flexibility in staffing that might not exist to the same extent with the use of full-time staff. Nevertheless, there are additional costs associated with providing benefits when staff work less than full time. For example, the health benefit cost to the state is the same per employee, and hence the hourly cost of providing this benefit is higher for temporary, part-time staff.

- Even when there is a sufficient number of authorized staff in a given area, a problem can occur when vacancies cannot be filled in a timely manner, and staff may have to work overtime. Management at the institutions was not aware of any analysis that has looked at the cost of overtime versus using full- or part-time staff.

Institutions Need Effective Staff Scheduling Tools and Control of Overtime

Effective staff scheduling and control of overtime has long been a focus in law, safety, and justice agencies; and its importance for inpatient institutions has been growing. Absent analysis, it is difficult for institutions to make the most cost-effective staffing decisions. In situations where staff are needed to work at fixed locations for defined periods of time (such as nurses' stations at hospitals), the most cost-effective schedules and mix of staffing and overtime can be determined if good data are available and the right analytical tools are employed. Conversely, if the data and tools are not available, staffing decisions are more arbitrary.

In recognition of and in response to this, a number of companies have begun offering software and on-line services to assist institutions in streamlining the staffing, allocation, and scheduling processes. These companies offer one possible approach to help achieve the provision of staffing resources at the least cost, while still meeting service objectives.

Many institutions and governmental agencies find it advantageous to do this kind of analysis with in-house staff, sometimes with the aid of scheduling software. An argument can be made for building this kind of analytical capacity within the department rather than contracting for it, because the cost may be lower, and in-house staff can retain an institutional knowledge base that is difficult, if not impossible, for outside experts.

In July 2005, the department created the position of Institutional Controller in part to provide more financial expertise and analysis for the institutions—something that has not been present in the recent past. Reviewing the duties of this position were beyond the scope and time limitations of this study, so we cannot comment on how well this new position might fulfill the needs of the institutions and address the specific problems that have been mentioned. Nevertheless, we concur with the idea of building analytical capacity within the department, and believe this should be a priority.

Challenges for the Department

Staffing and workload at the Department of Health and Welfare presents both challenges and opportunities.

Probably the most difficult challenge for program staff and managers is to be able to respond in the most effective manner when budget realities restrict funding for staff. In order to make a convincing case that they need more staff, they must first demonstrate that they are using their existing resources efficiently and effectively.

Presently, some of the largest program areas of the department lack well developed staffing and workload models, rely on simple formulae, or have no method in place to assist with staffing decisions. This lack of methodology limits the ability of programs to assess staffing needs, identify the most cost-effective work processes, react optimally to changes in funding levels, and to assist the Legislature in understanding the relationship between funding, staffing, and service delivery.

Recommendations

5.1: The Department of Health and Welfare should leverage its expertise and experience to set standards for and to develop more useful workload and staffing models for programs that would benefit from them.

5.2: The Department of Health and Welfare's Division of Welfare should evaluate the reasons for staff perceptions that workload adjustments are not made when needed, and include an evaluation of options and expected results of applying alternative methods of balancing workloads among offices.

5.3: The Department of Health and Welfare should evaluate alternatives, including the development of in-house analytical capacity, to assist the state hospitals in identifying the most cost-effective staffing, allocation, and scheduling methodologies.

Chapter 6
Employee Turnover

High employee turnover can negatively impact the budget and productivity of an agency. In recent years, the Department of Health and Welfare's overall turnover rate has exceeded the average level of turnover in state government. Our analysis of turnover in specific divisions, programs, and work locations within the department show that turnover varies, sometimes considerably, depending on the area of the organization. The department has not monitored turnover for specific divisions, programs, and locations. Because of the consequences turnover can have on agency operations, the department should make changes to its personnel data that will allow it to more specifically monitor employee turnover.

High Employee Turnover Can Have Negative Consequences

The retention of employees is important to the efficient and effective operation of an organization. The Idaho Division of Human Resources lists the support of employee retention as one of nine major goals in providing personnel services for Idaho state government. The US Office of Personnel Management explains that emphasis on employee retention can help an organization keep its "valuable human capital assets" and get more out of the investments made in employees.[1]

Although turnover within an organization can have some positive effects, it brings negative consequences that can impact performance and budgets. According to the Congressional Budget Office, employee turnover results in costs for the recruitment and training of replacement staff, lost productivity due to vacant positions, increased supervisor demands over new employees, and limited expertise of replacement workers.[2] Of the Department of Health and Welfare staff and supervisors responding to our survey, 90 percent indicated that turnover was an impediment to the agency's effectiveness.

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[1] US Office of Personnel Management, *Workforce and Succession Planning, Retention Management,* www.opm.gov/hr/employ/products/workforce/retention.asp.

[2] Congressional Budget Office, *Employee Turnover in the Federal Government* (1986), 11, 27, and 30.

Department of Health and Welfare Turnover Exceeds the Overall State Average

Each year the state's Division of Human Resources calculates turnover rates for state agencies. As shown in exhibit 6.1, the Department of Health and Welfare's turnover rate has exceeded the state average each of the past three fiscal years. In addition, the department's turnover rate is greater than most other large state agencies. During the three year period, only the Department of Correction had a higher rate of turnover.

Factors Impacting Turnover

Employees responding to our survey cited several reasons they believe are causes of department turnover. Staff and supervisors reported the following reasons as those that most impact department turnover (listed with the percentage of respondents that indicated each reason):

- Pay (84.5 percent)
- Level of stress at work (52.9 percent)
- Workload (36.8 percent)
- Management (26.8 percent)

Middle managers reported similar reasons as causes for department turnover. In addition, the department reports that information collected from its exit interviews indicates pay as the top reason workers leave, followed by employees having obtained a better job.

Exhibit 6.1: Turnover Rates of Largest State Agencies, by Fiscal Year

	2003	2004	2005
Department of Health and Welfare	15%	17%	17%
Department of Correction	18	18	18
Idaho Transportation Department	8	7	8
Department of Commerce and Labor	9	11	14
Average state turnover	**13%**	**13%**	**14%**

Source: Office of Performance Evaluations' review of Idaho Division of Human Resources' publication, *Idaho State Employee Compensation Report Supplement* (2005).

Additional Funds Requested to Address Turnover

In addition to information about overall turnover rates, the state's Division of Human Resources prepared data about turnover for certain positions within the department. The department used the turnover information for these job classifications to present legislative germane committees with its request for a $2.2 million budget enhancement for fiscal year 2007. The funding request was for salary increases to address recruitment and turnover problems for positions such as nurses, physicians, social workers, and pharmacists.

As shown in exhibit 6.2, our review of fiscal year 2005 turnover for health care related positions specified in the department's budget request showed that turnover rates varied, but were high for a number of occupations.[3] Turnover for the various nursing positions exceeded the department's overall average. For physicians, however, no turnover was reported in the fiscal year.

[3] For some of these job classifications, the total number of positions was not high. As a result, each employee that leaves the department may have a large impact on the turnover rate for a particular job classification.

Exhibit 6.2: Turnover Rates for Selected Job Classifications in the Department of Health and Welfare, Fiscal Year 2005

	Turnover Rate	Total Number of Positions
Nursing Services Director	100.0%	1
Registered Nurse Managers	60.0	10
Clinical Pharmacists	33.3	6
Registered Nurses	32.6	46
Licensed Practical Nurses	28.3	60
Senior Registered Nurses	20.9	67
Clinicians	17.9	179
Social Workers	17.8	230
Clinical Supervisors	10.0	40
Physicians	0.0	13

Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solution (IBIS).

Turnover Varies Among Divisions, Programs, and Work Locations

Although the Idaho Division of Human Resources annually calculates turnover rates for the department overall and for particular job classifications, the information does not offer insight to turnover within particular department divisions, programs, or work locations. Because available analysis has been limited, we analyzed turnover among individual divisions, programs, and work locations within the department.[4]

To assess turnover in these areas, we obtained information for fiscal year 2005 about the total number of department positions and about the positions vacated by employees.[5] Our analysis addressed only permanent positions and employees, and we counted all separations, terminations, and interagency transfers as turnover.[6] After determining the division, program, and work location of each position, we calculated turnover rates by comparing the number of turnovers in a given area to the total filled positions in that area.

Turnover by Division

As discussed in chapter 1, the department has multiple divisions that encompass the individual programs providing services. Turnover rates for each of the department's divisions are presented in exhibit 6.3. As shown, turnover rates varied somewhat among divisions. The Division of Family and Community Services and and the Division of Health had the highest rates of turnover at just over 19 percent, and the divisions of Human Resources and Medicaid had the lowest. The size of the divisions did not appear to be a factor in turnover rates, with the Division of Family and Community services having the greatest number of total employees and the Division of Health having the smallest number.

Turnover by Program

Exhibit 6.4 shows that turnover within individual department programs varied widely. Individual program turnover ranged from a high of 35.1 percent in Vital Statistics to a low of 3.9 percent in Welfare Support. In addition to Vital Statistics, other programs with relatively high turnover rates included Idaho State School and Hospital (29.6 percent) and Emergency Medical Services (25.9

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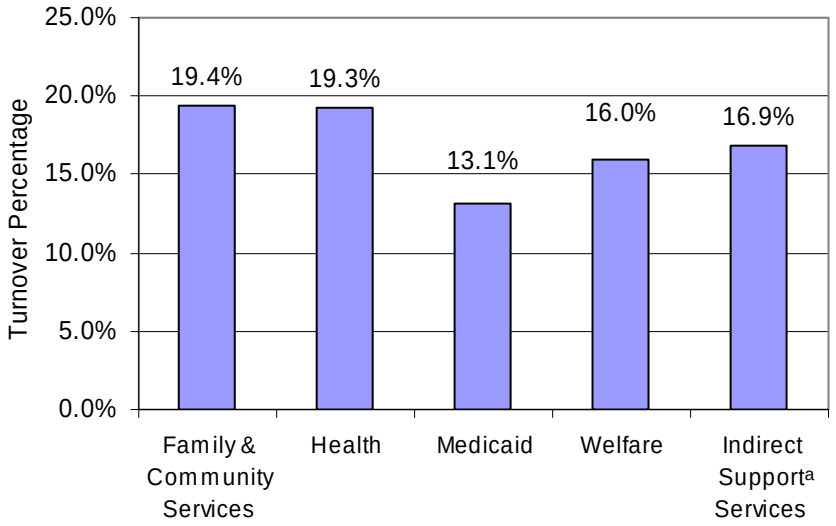
[4] The data used in our analysis differed slightly from that used by the Division of Human Resources. For instance, while the division's analysis focused only on classified staff, we included both classified and non-classified permanent positions in our analysis.

[5] Due to challenges in obtaining complete historical data, this analysis only covered the most recently completed fiscal year.

[6] Our analysis did not include positions vacated because an employee transferred to a different position within the department.

Exhibit 6.3: Turnover Rates in the Department of Health and Welfare, by Division, Fiscal Year 2005



[a] Includes the Division of Human Resources, Division of Management Services, Information and Technology Services Division, and the Office of the Director.

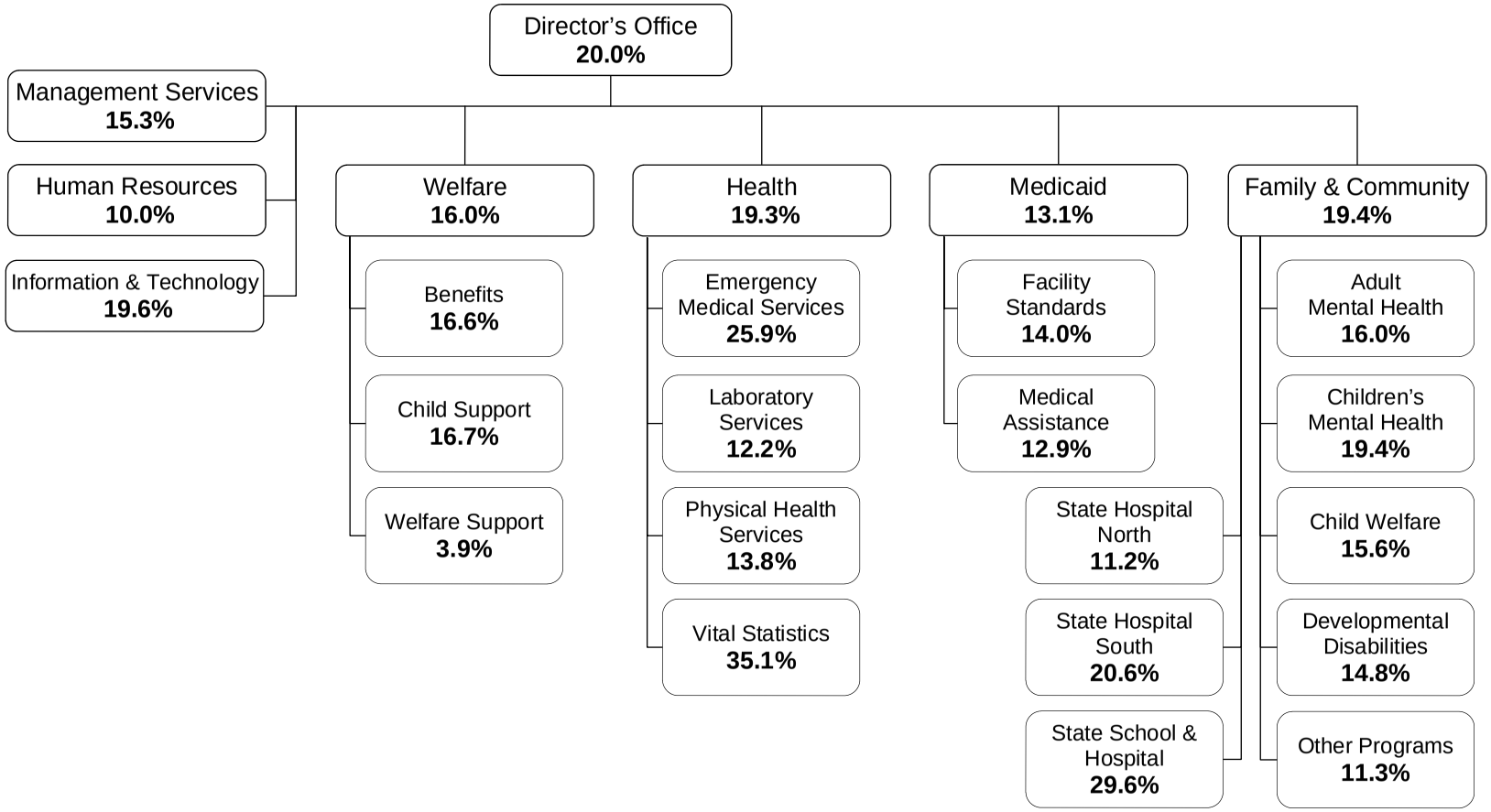
Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solution (IBIS) and the Department of Health and Welfare.

percent). Aside from Welfare Support, State Hospital North in Orofino was the program area with lowest turnover rate in fiscal year 2005 (11.2 percent).

Turnover by Work Location

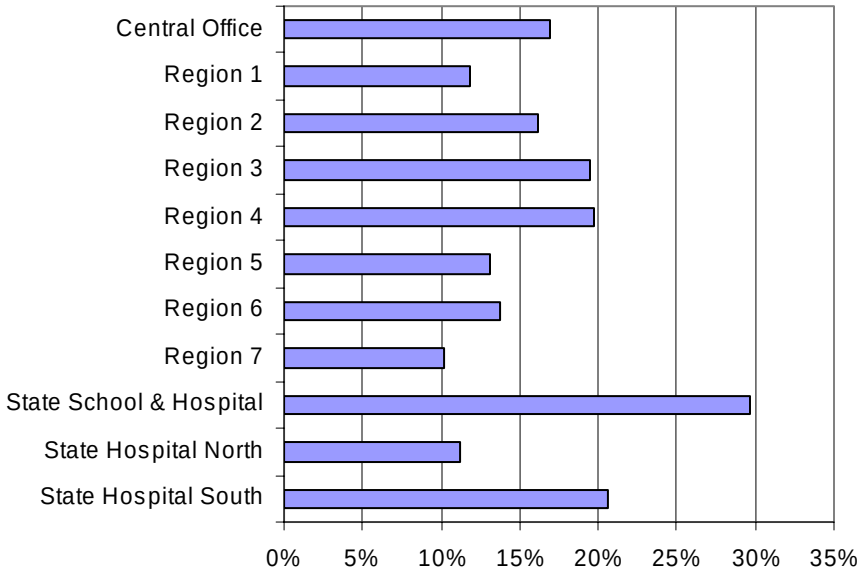
The department's turnover rates also varied among the different locations where employees work. As shown in exhibit 6.5, turnover in particular work locations ranged from about 10 percent in Region 7 to nearly 30 percent at the Idaho State School and Hospital. The department's Treasure Valley work locations—including Region 3, Region 4, and Idaho State School and Hospital—tended to have some of the higher turnover rates. State Hospital South, located in Blackfoot, also had a relatively high percentage of workers who left during the fiscal year.

Exhibit 6.4: Turnover Rates in the Department of Health and Welfare, by Division and Program, Fiscal Year 2005



Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solution (IBIS) and the Department of Health and Welfare.

Exhibit 6.5: Turnover Rates in the Department of Health and Welfare, by Work Location, Fiscal Year 2005



Source: Office of Performance Evaluations' analysis of personnel information from the Office of the State Controller's Idaho Business Intelligence Solution (IBIS) and the Department of Health and Welfare.

Department's Turnover Analysis Is Limited

Despite the impact that turnover can have on an organization, the department's personnel data is not set-up in a manner that readily allows detailed analysis and monitoring of trends. The department's data structure hinders the opportunity for easy or accurate analysis about turnover in particular divisions, programs, and facilities.

As previously discussed, the information about department turnover has been focused on overall turnover rates, and rates within particular job types and department facilities. Although this information provides a useful understanding of job types where retention difficulties may be present, it does not provide department officials with insight into specific areas where management, morale, or other problems may be negatively impacting the staff, and subsequently, the performance and fiscal resources of the agency.

Recommendation

6.1: The Department of Health and Welfare should make changes to the structure of its personnel data to allow for regular monitoring of turnover rates in specific divisions, programs, and work locations, as well as by job classification.

Potential Areas for Further Study

We identified four program areas where turnover exceeded 20 percent. These areas may warrant further study.

- Vital Statistics, Division of Health
- Emergency Medical Services, Division of Health
- Idaho State School and Hospital in Nampa
- State Hospital South in Blackfoot

Chapter 7
Board of Health and Welfare

The Idaho Board of Health and Welfare is charged by Idaho Code with making rules for the protection of personal health, and for relevant licensure and certification matters. The board is also hears appeals from persons aggrieved by the Department of Health and Welfare. Boards and commissions of other large Idaho agencies have much greater responsibilities under Idaho Code. Although members of the Board of Health and Welfare are satisfied with their comparatively limited role, the involvement of the board in departmental affairs could be strengthened.

Health and Welfare Board Is Charged with Rulemaking and Hearing Appeals

Idaho Code directs the Board of Health and Welfare to serve three functions:[1]

- Hear appeals—with authority to certify oaths and issue subpoenas—from persons aggrieved by actions of the Department of Health and Welfare
- Adopt, amend, or repeal Health and Welfare standards and rules, including fees, regarding the maintenance and protection of personal health and relevant licensure and certification requirements[2]
- Concur or dissent, by vote, with regional director and division administrator appointments made by the director of the Department of Health and Welfare

Other Idaho Boards Have Greater Responsibility

The Board of Health and Welfare's rulemaking and appeals hearing role is limited when compared to other relatively large Idaho agency boards and commissions:

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[1] IDAHO CODE §§ 56-1003(1)–(2), -1005, -1002(2)–(3).

[2] Idaho Code authorizes the director of Health and Welfare to prescribe rules for the administration of department business, including personnel matters and the disposition of department records and state property. IDAHO CODE §§ 56-1004(1)(a).

- **The Board of Correction** is authorized by the Idaho Constitution (Article X, § 5), and by Idaho Code §20-201. This governor-appointed three-member board is responsible for the control, direction, and management of all correctional facilities and property. The board promulgates all of the department's administrative rules, and delegates responsibility to the director of the Department of Correction.
- **The Board of Environmental Quality** is authorized by Idaho Code §39-107. This governor-appointed seven-member board promulgates all of the department's administrative rules, meets an average of six times per year, and approves funding prioritization for certain department projects.
- **The Board of Juvenile Corrections** was created by Executive Order 97-18. This five-member board is jointly appointed by the Governor, the chairs of the Senate Judiciary and Rules Committee and the House Judiciary, Rules, and Administration Committee. The board is involved with fiscal, policy, and administrative issues and develops goals and standards to evaluate the department's effectiveness. In contrast with the Board of Health and Welfare, the Board of Juvenile Corrections includes voting members of the legislature and meets monthly.
- **The Fish and Game Commission** is authorized by Idaho Code §36-102. This seven-member, governor-appointed commission is charged with supervision, management, and control of the Department of Fish and Game. The commission also approves department budgets prior to submission to the legislature. The commission meets an average of eight times per year.
- **The Idaho Transportation Board** is authorized by Idaho Code §40-301 to control, supervise, and administer the Department of Transportation. As a significant contrast to the Board of Health and Welfare, Idaho Code §40-503 charges the seven-member Transportation Board with appointing the department director, who serves at the board's pleasure. In addition to special meetings, the board holds regular meetings at least 12 times per year.
- **The Parks and Recreation Board** is authorized by Idaho Code §67-4221 and includes six Governor-appointed members who meet on average four times per year. Idaho Code requires the board to administer, conduct, and supervise the Department of Parks and Recreation. The board is also required to appoint a director to serve at its discretion, and has the authority to make rules, appoint local advisory councils, administer funds, and acquire land.

Approaches Taken by Neighboring States Vary Widely

Based on a review of statutes in six neighboring states, we found a wide degree of variation when compared to the Idaho Board of Health and Welfare. For example, the Washington State Board of Health, the Oregon Public Health Advisory Board, and the Nevada Board of Welfare have reporting obligations established in statute. In contrast, the Idaho Board of Health and Welfare has no reporting obligations under Idaho Code.

No single model for boards governing or advising state agencies that provide health and human services is common among our neighbors. However, a number of aspects are relevant to understanding the current role of Idaho's Board of Health and Welfare:

- **Most states separate health services and welfare services.** There is no direct equivalent to the Idaho Board of Health and Welfare in neighboring states. This is because only two states, Oregon and Montana, have single agencies similar to Idaho's Department of Health and Welfare. The remaining four of Idaho's neighbors separate public health and public welfare into distinct executive agencies. Furthermore, neither Oregon's nor Montana's agencies are governed by a board equivalent to the Idaho Board of Health and Welfare.
- **Some states have no board governance over welfare services.** Welfare services in Washington and Oregon are not governed by state or local boards.
- **Some states' services are governed by local boards.** Health services in Utah, Wyoming, and Montana rely on boards that govern at local levels, each with self-governance and rulemaking authority (welfare services in Wyoming and Montana are also guided by local boards).
- **Some states' services are governed by state-level boards.** As shown in exhibit 7.1, Washington and Oregon have established health boards at the state level. Nevada has established a state board of health and a state board of welfare. Of these, the boards of health in Washington and Nevada have rulemaking authority over non-administrative matters of public health. Welfare programs in Utah are governed by a number of boards within the Department of Human Services, each carrying primary rulemaking authority over a specific topic area.

Members of Idaho's Health and Welfare Board Prefer a Limited Role

To gain more information about the role and activities of the Idaho Board of Health and Welfare, we interviewed all five current members (two board seats

Exhibit 7.1: Comparison Between Idaho's Board of Health and Welfare and State-Level Bodies in Neighboring States

	Size	Membership Guidelines[a]	Significant Roles	Meetings (approx.)	Reporting	Staff	Budget
Idaho (Board of Health and Welfare)	7	Representatives with interest and knowledge; no more than 4 from one political party; with Senate consent	• Make rules (public health) • Hear appeals • Review department appointees	4/year	None	agency support	per diem
Nevada (Board of Health)	7	Doctors of medicine, veterinarian, dentist, nurse, general engineer/ building contractor, general public	• Make rules (public health, including cities and counties) • Provide agency rule hearings	7/year	Legislature	agency support	per diem
Nevada (Board of Welfare)	7	Representatives with interest and knowledge; no more than 3 members from a single county	• Consider public assistance matters • Make recommendations based on public testimony to legislature, governor, agency	12/year	Legislature, Governor, agency	agency support	per diem
Oregon (Health Policy Commission)	14	Citizens (a majority not providers) from each congressional district: representing geographic, social, economic, occupational, linguistic, ethnic populations, rural and urban medically-underserved; a physician; 2 legislative appointees from each party	• Develop state health plan • Oversee statewide data collections • Provide forum for policy discussion • Analyze significant issues • Recommend policy changes and reforms to lawmakers • Review changes to Medicaid	11/year	Governor, Legislature, agency	2 FTEs; agency support	per diem; $300,000
Oregon (Public Health Advisory Board)	15	Citizen representatives of the state, Oregon Health Policy Commission, local government, health professionals, a consumer	• Make recommendations to agency • Review statewide health • Participate in policy development • Provide advocacy for veterans	4/year	Legislature, Emergency Board, agency	agency support	per diem
Washington (State Board of Health)	10	Health and sanitation experts, elected city & county officials of local health boards, local health officer, consumers	• Provide forum for public inclusion in policymaking • Make rules (public health) • Advise agency	9/year	Governor, public	2 FTEs; agency support	per diem; $860,535

Note: Welfare services divisions within the Utah Department of Human Services are governed by a number of state-level boards, each with rulemaking authority. The Utah Department of Health, and both health and welfare services in Wyoming and Montana are governed by local boards. Welfare services in Oregon and Washington are not board governed.

[a] Members of all the boards and commissions reviewed here are appointed by their respective governors.

Source: Office of Performance Evaluations' analysis of Idaho, Nevada, Oregon, Washington, Montana, Utah, and Wyoming data and statutes.

were vacant). Generally, board members did not express dissatisfaction with the current extent of their responsibilities. Although all five members understood the board's functions—to make rules and preside over grievance hearings—one member said clarification of the board's role would be helpful. Another member felt the board's main objectives were to act as a watchdog and to act as a hearing board regarding department decisions.

During recent years, regular meetings of the board have occurred twice annually.[3] Board members were in agreement that the frequency of meetings was sufficient. Some board members indicated the department had provided sufficient orientation, although one member suggested the board would benefit from a tour of department facilities to better understand the functions of the department.

Involvement with Department Management Issues

Currently, the board does not have an active role in the department's strategic planning, budget setting, or other management functions. Two members commented that since the Division of Environmental Quality formed an agency separate from the Department of Health and Welfare, the Board of Health and Welfare's workload has decreased dramatically. As Idaho Code requires the Health and Welfare director to prescribe rules for the administration of the department, board members indicated they believe it is not the intended function of the board to be involved in management issues. Board members cautioned against additional oversight functions for three reasons:

1. Members lack professional expertise in, e.g., business or finance
2. Additional oversight would require too much additional time
3. Departmental complexity would make informed decisions difficult

One board member further indicated that, considering a lack of specific expertise, involvement by the board or the Legislature in department management or daily operations may be improper.

Interaction with Legislators

Interaction between the board and the Legislature has been limited. In the past, some legislators have attended board meetings, but this is not a regular occurrence. Although the current chairs of the Senate and House Health and Welfare Committees are invited to attend meetings as *ex officio* non-voting members, this is not formally established in Idaho Code and was not uniformly communicated to these legislators.[4] Neither legislator has attended board

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[3] Special meetings of the board are scheduled "as necessary and from time to time." In recent years, the board has met 3 to 5 times per year. IDAHO CODE § 56-1005(3).

[4] IDAHO CODE § 56-1005(1)–(3).

meetings as an *ex officio* member. One board member told us attendance by the *ex officio* members could be helpful. For example, legislators could help address language in proposed rules that will eventually be reviewed by legislative committees.

Idaho's Board Could Be More Involved

The Legislature could expand the involvement of the Board of Health and Welfare in department affairs through a number of means, which may involve some expansion of the size of the board and the frequency of its meetings:

1. Increasing board oversight to include supervision, management, planning, and budgeting
2. Requiring annual reports from the board to the Governor and Legislature detailing how the board has addressed its statutory mandate to adopt rules pertaining to health and relevant licensure and certification, hear appeals, and review management appointments by the director of Health and Welfare
3. Requiring board concurrence on departmental budgets and strategic plans
4. Requiring the administrators of all Department of Health and Welfare divisions to report to the board at each meeting on specific issues of interest to the board, or on established performance measures (currently, only the director reports to the board regarding the agency as a whole)
5. Ensuring board members possess appropriate professional expertise or have access to additional training as needed to carry out the charge of protecting the health of the state

Chapter 8
Facility Planning, Maintenance, and Funding

In recognition of the importance of facility planning, maintenance, and funding, governmental agencies at the federal, state, and local level have compiled best practice guidelines that can be followed to ensure that resources devoted to facilities are effectively managed. Following best practices has the advantages of identifying the most cost-effective approaches to safeguarding taxpayers' investments, and ensuring that government operations and client services are not disrupted by system and equipment failures.

Failing to follow best practices can cause both immediate and long-term problems, such as:

- *Responding to maintenance problems on an emergency, rather than a planned basis*
- *Not obtaining the full useful life of assets*
- *Incurring additional costs associated with maintaining obsolete and ill-repaired buildings, systems, and equipment*

In this chapter we describe how the Department of Health and Welfare is at risk of, or is presently experiencing, problems in all of these areas. We also note that the department is not taking full advantage of federal financial participation in paying for buildings and equipment. It is unclear, however, whether the issues that have come to our attention are limited to the department, or whether they are more systemic within state government. The Legislature may wish to consider further study in this area, and as one option, focus on the Department of Health and Welfare institutions as a case study.

Institution Management Expressed Concerns About Facility Planning, Maintenance, and Funding

Having an effective process for facility planning, maintenance, and funding is an important part of resource management, especially in an agency such as the Department of Health and Welfare where facilities play an important role in the direct provision of services. Currently the department operates three inpatient institutions that house and provide care for some of the state's most vulnerable

clients. State Hospital North in Orofino serves acute, court-committed psychiatric patients. The Idaho State School and Hospital in Nampa serves severely impaired people with developmental disabilities. State Hospital South in Blackfoot provides psychiatric treatment and skilled nursing to adults and adolescents with serious mental illnesses.

In our initial site visits to discuss issues related to staffing, institution management brought to our attention several issues related to how facility layout, design, and maintenance had an impact on staffing needs. We also heard concerns that failure to effectively address facility needs was having negative consequences in terms of service delivery, and was creating long term financial liabilities. In response to these concerns, we conducted further interviews with institutional and headquarters staff, and with staff in the Public Works Division of the Department of Administration. We also gathered additional information on the capital planning and budgeting process for the institutions and compared what we learned about this process to recognized best practices.

In the following section of this report we describe the best practices, the reasons for them, and indicate current conditions and practices that do not adhere to the best practices.

Best Practices Are Part of a Cycle of Effective Management

In this chapter, we discuss what we have learned from our evaluation of current practices in the department and in relation to five best practice categories. Although each best practice category is important in its own right, success in each area is linked to success in other areas. Effective long-term planning and analysis of facility status can set the stage for identifying needs, selecting appropriate investments, and implementing a process of preventive maintenance, which must be made possible by creating the means to ensure that funding is available when needed. Exhibit 8.1 shows a schematic of these relationships.

The steps in the cycle of effective planning, maintenance, and funding are becoming so well recognized and accepted that calling them “best practices” may seem to be a misnomer.[1] Instead, they might rightly be labeled as necessary steps. Nevertheless, the reality is that as important as they are, especially from

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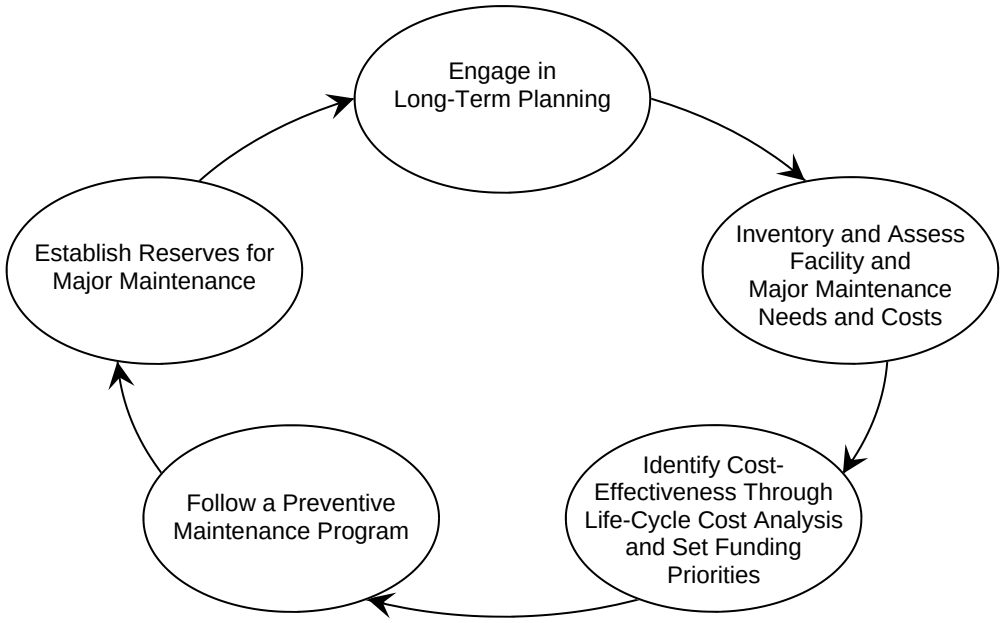
[1] US Department of Energy, Federal Energy Management Program, *Operations & Maintenance Best Practices: A Guide to Achieving Operating Efficiency*, Release 2.0 (July 2004), 5-1; US Government Accountability Office, *Leading Practices in Capital Decision Making* (December 1998); Minnesota Office of the Legislative Auditor, *A Best Practices Review: Preventive Maintenance for Local Government Building* (2000); Alaska Department of Education and Early Development, *Alaska School Facilities Preventive Maintenance Handbook* (1999); Florida State Office of Program Policy Analysis and Government Accountability, *Facilities Maintenance Best Practices* (2002).

Exhibit 8.1: Cycle of Effective Facility Planning, Maintenance, and Funding



Source: Office of Performance Evaluations' literature review.

the standpoint of sound fiscal management, these best practices are not universally followed. According to a recent guide to best practices by the US Department of Energy, the majority of facility maintenance in the United States is still carried out in an inefficient "reactive" mode that can have unintended, or at least undesirable, fiscal consequences.[2]

In the following sections, we will discuss each best practice, why it is important, and to what extent the department adheres to the practice. Because the department's practices take place within the context of the state's overall capital planning and funding process, we will also discuss the larger context as appropriate.

Engage in Long-Term Planning

Long-term planning that incorporates an assessment of facility and maintenance needs is an important part of meeting overall agency and program goals and objectives. Long-term planning helps ensure:

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[2] US Department of Energy, Federal Energy Management Program, *Operations & Maintenance Best Practices: A Guide to Achieving Operating Efficiency*, Release 2.0 (July 2004), 5-1.

- Needed assets are funded and in place to support operations
- Investments are not made in maintaining facilities that are inefficient, have exceeded their useful lives, are obsolete, or are no longer suited well to program needs

A recent consultant study conducted for the institutions focused on an evaluation of current and projected demand for community-based residential beds, crisis intervention, and inpatient psychiatric hospital beds.[3] This study also provided summaries of some major facility issues and the high priority near-term capital requests as defined by the institutions. As such, it may be viewed as a high-level analysis that represents a start in the direction of developing a long-term plan. However, based on our interviews with staff from the institutions, there still is a need for a more *comprehensive and detailed* long-range plan identifying facility needs in relation to the population to be served, and the system (e.g., plumbing, heating, and cooling) and equipment upgrades required by those facilities.

Some specific examples of facilities issues identified in our interviews, and the recent analysis by the consultants, include:

- Campuses at both the Idaho State School and Hospital (ISSH) and State Hospital South at one time housed much larger client populations and still have some infrastructure in place suitable for a larger population. ISSH is situated on 85 acres and has 18 buildings, some of which were built between 1916 and 1964. Currently, the campus houses approximately 92 clients. Although three of the five residential buildings are new (built in 2003), some of the buildings, such as the Medical building, are only partially used, and others are used primarily for storage.
- Idaho State School and Hospital campus buildings are spread out, requiring staff from the units to escort patients from place to place and accompany them while they are away from their living units. The same situation prevails at State Hospital South.
- The State Hospital South nursing facility is housed in a multi-story building in which three stories are used for patients. The separation of housing units and service areas by floor location, and the reliance on elevators to move patients in wheelchairs, introduces staffing inefficiencies, impairs operations, and jeopardizes safety (such as when the elevators do not function properly).
- The State Hospital North facility is relatively new. There are two treatment units, both with 30-bed capacities. One unit, however, uses only a maximum of 20 beds. It was originally designed to be a substance

[3] Department of Health and Welfare, The Mental Health Facilities Development Plan, Myers-Anderson and The Estimé Group, Inc. (September 2005).

abuse treatment unit for patients voluntarily admitted, and who could have more freedom of movement. The unit is now used as a psychiatric unit and requires more space for treatment.

A comprehensive long-term plan would address which buildings and facilities are needed, whether some buildings should be replaced, and whether further investments in buildings (in terms of major system repair and replacement) are economically justified.

Create an Inventory and Assessment of Facility and Major Maintenance Needs and Costs

Within a long-term plan, and in order to provide adequate preventive maintenance, it is necessary to have an inventory of assets, and a current record of their condition and knowledge about their expected remaining useful lives. For capital decision-making, it is also necessary to have an understanding of the costs of maintaining building systems and equipment to achieve their useful lives, and of the cost for eventually replacing them.

By all accounts, there currently does not exist a comprehensive inventory or assessment of these needs and costs for the inpatient institutions.

An inventory would provide decision-makers, including the members of Idaho's Permanent Building Fund Advisory Council, with the information they need to determine how revenue sources for major maintenance and replacement projects match needs, and to what extent the state may have unfunded liabilities associated with its facilities.

Set Funding Priorities and Use Life-Cycle Cost Analysis to Identify the Most Cost-Effective Alternatives

Not all capital and maintenance projects have the same return on investment. For example, in some cases it may be more economical to replace inefficient buildings instead of continuing to operate and maintain them. Life-cycle cost analysis of alternatives is a way to look at total costs of alternatives over time in order to identify the least costly way of addressing facility needs.

The situation explained to us by institution staff, and confirmed by headquarters staff, is that each year headquarters staff visits the facilities in June and July, and updates its information on replacement and maintenance needs. However, this is not a comprehensive assessment—according to the department, it only covers an estimated 75–80 percent of the most pressing needs.

As described to us, this process eventually results in the creation of a list of 20 to 30 high priority projects that the department submits to the Permanent Building Fund Advisory Council, which, in turn, is usually able to fund less than half of the requested projects.

Because the original list submitted covers only about 75–80 percent of the most pressing needs, and less than half of these needs get funded, the funding process creates a catch-up situation where the agency and the institutions can get further and further behind. If a system fails, but was not previously approved for funding, the money for the necessary repair or replacement has to be found in the operating budget of the agency or institution. Because operating funds are used for maintenance and repairs, this means there can be even less money available for the next system or equipment breakdown.

Life-cycle cost analysis could demonstrate, for decision-makers, not only the projects that would be the best investments, but allow them to prioritize these projects in terms of return on investment and service impact. Although the department headquarters points to past life-cycle cost analyses on some major projects, such as the new residential buildings at ISSH, institutional staff report that conducting such analyses is not routinely done.

Establishing a system to anticipate and comprehensively inventory facility replacement and maintenance needs, and utilizing life-cycle cost analysis, would assist decision-makers to identify the most cost-effective alternatives.

Follow a Preventive Maintenance Program

Preventive maintenance means not only the regularly scheduled repair and maintenance needed to keep facilities, systems, and equipment operating at peak efficiency and attain their useful lives, but also includes the regular inspections and analyses needed to ensure that preventive maintenance activities are warranted and cost-effective.

To its credit, the Department has been using a software program to assist in managing a preventive maintenance program for its department-owned regional building, and the institutions are now implementing the use of the same software. Staff and management at the three state institutions report, however, that reactive, rather than preventive, maintenance has been the norm for years and continues to be a problem. The reasons they cite include lack of funding, cutbacks in staffing, compensation packages that are too low to attract and retain the most competent staff, and problems in communicating with headquarters about their facility and staffing needs.

Establishing a method to provide for, and carrying out, preventive maintenance would promote:

- Having systems and equipment that are kept in good operating condition, which helps to ensure that they maintain their intended functionality
- Avoiding the higher costs of premature or emergency repairs or replacements

- Reducing disruptions of operations and inconveniences to clients and staff, and unsafe conditions

Establish Reserves for Major Maintenance

Major maintenance repairs and equipment replacements vary from year to year, and some years require larger expenditures than others. A best practice for prudent financial management and capital planning is to create a reserve account for these expenses. Prospectively, it is possible to estimate the costs of each of these expenses over the useful lives of assets and invest needed funds in a reserve account, similar to a sinking fund which through annual charges to the user(s) of the assets will provide sufficient funds.[4]

Establishing reserves for major maintenance would prevent the downward spiral that can occur when assets deteriorate from a lack of investment, creating more expense in the long term. It would also avoid the funding of projects on an emergency basis, giving decision-makers little choice but to address the emergency, sometimes at the expense of other meritorious projects.

An example of how one government in King County, Washington, established and operates a reserve fund is provided in appendix E. Other examples exist throughout the country, especially in higher education and the private sector.

In the next three sections of this chapter we will provide an overview of how major maintenance for the institutions is currently funded, concerns about the funding process, and our conclusions about the situation that results from not following best practices.

How Is Major Maintenance Funded?

In the Department of Health and Welfare, major projects for the institutions have been funded through the Permanent Building Fund, bonds issued by the State Building Authority, and the department's operating budget.

Examples of major projects include:

- The administration building at State Hospital South was funded directly from the Permanent Building Fund
- The construction of State Hospital North was funded through bonds issued by the State Building Authority

[4] A sinking fund is a fund into which a company or governmental entity sets money aside to retire debt or for funding other liabilities. Making incremental payments can soften the financial impact of paying for debt at maturity or for capital expenditures when emergencies occur.

- The Idaho State School and Hospital's new housing units were funded by bonds whose debt service is paid by the department's operating budget appropriated by the Legislature

According to department headquarters staff, only those projects over $30,000 are eligible for funding by the Permanent Building Fund.

The Permanent Building Fund Advisory Council was established in 1961 when an ongoing revenue source was created. Its five members are appointed by the Governor with fixed terms, and they serve at the pleasure of the Governor. The council is comprised of one member of the Senate, one member of the House of Representatives, a citizen engaged in the contracting business, a citizen engaged in the banking business, and a citizen who is a member of the business community not engaged in contracting or banking. The Senate member and House of Representatives member are appointed for a fixed term of two years. All other council members are appointed for a fixed term of three years. Sources of funding for the Permanent Building Fund are:

- $10 tax on income tax filings
- $5 million per year from sales taxes
- Part of the tax on cigarettes, amounting to $.0813 per pack
- Part of the tax on beer, amounting to about $1.53 per barrel
- One-half of state lottery earnings
- Interest earnings on its own fund balances invested by the State Treasurer, and interest on the Budget Stabilization Fund

Monies in the Permanent Building Fund are dedicated to building structures, renovation, and repairing existing structures at state-owned facilities.

Adequacy of Funding Remains a Concern

The Governor and the Legislature have indicated concerns over the adequacy of funding available to state-owned facilities through the Permanent Building Fund.[5] From our interviews with the institutions and headquarters staff, and with staff of the Public Works Division in the Department of Administration, we learned that problems with the adequacy of funding continue, not just in relation to the Permanent Building Fund, but also with monies available through the operating budget. As previously mentioned, the full extent of the problem is not known due to the lack of a comprehensive assessment of the institutions' facility and equipment needs.

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[5] Executive Office of the Governor of the State of Idaho, Governor Dirk Kempthorne, *State of the State and Budget Address Before a Joint Session of the First Session of the 58th Idaho Legislature* (January 10, 2005); and S. Con. Res. 159, 55th Leg., 2nd Sess. (Idaho 2005) (unenacted).

Deferring Investments Also Defers Tapping into Federal Funds

Deferring the replacement of inefficient assets and major systems denies the institutions access to funding participation by the federal government and compounds their funding problem.

According to information provided by department headquarters, the Idaho State School and Hospital and several of the facilities at the State Hospital South receive federal funds for operations. Based on funding rules set by the federal Office of Management and Budget, depreciation and use allowances will be paid by the federal government as means of allocating the cost of fixed assets to periods benefiting from asset use. Compensation for the use of fixed assets on hand may be made through depreciation or use allowances.[6] In the case of the Idaho State School and Hospital, for example, the federal financial participation rate for operations and for paying for fixed assets is about 70 percent.

The department currently captures federal financial participation for assets that are eligible for, and have not exhausted, their depreciation. Nevertheless, the department cannot tap into federal funds until expenditures are made. As long as projects are deferred, federal financial participation is also deferred. In effect, this amounts to tapping into a stream of revenue later instead of sooner, and therefore postponing the benefit of that revenue. One reason why public entities may delay benefiting from eligible federal participation is because expenditures for assets must occur first. This potential obstacle can be partially (or largely) overcome by financing the purchase of the asset with debt, or by having a reserve funding system already in place.

Federal financial participation is a term used by the federal government to denote when it will participate with a state in the costs related to administering a program. The method used by state agencies to determine how and which costs are used to claim the participation is through a cost allocation method developed by the state. The percentage of participation can change during the year based on activities being conducted or new grants that have been awarded.

In response to questions we posed, we learned that neither the Permanent Building Fund Advisory Council nor the department explicitly considers the availability of federal funding participation when setting project priorities or making funding decisions, at least in the case of the Health and Welfare's projects. However, we were further advised that the Department of

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[6] Where the use allowance method is followed, the use allowance for buildings and improvements (including land improvements, such as paved parking areas, fences, and sidewalks) will be computed at an annual rate not exceeding two percent of acquisition costs. The use allowance for equipment will be computed at an annual rate not exceeding 6⅔ percent of acquisition cost. Executive Office of the President of the United States, Office of Management and Budget, *OMB Circular A-87*, 11.f.

Administration could take advantage of such information if it were made available. We also learned that funding for depreciation currently goes into the institutions' operating budgets where it can be used to subsidize non-facility operating costs.

Federal assistance in the form of depreciation or use allowances could create a source of dedicated funding for a major maintenance reserve fund.

Conclusion for Facility Planning, Maintenance, and Funding

As described at the beginning of this chapter, the steps within a cycle of effective facilities planning, maintenance, and funding are tied together. A key step within the cycle is preventive maintenance, which serves to protect investments and avoids funding by emergency. Developing a preventive maintenance plan, however, in the absence of a system to inventory assets and establish sufficient funding, is not likely to be effective. Therefore, the first three building blocks for such a plan are the creation of:

- A comprehensive, long-range plan that identifies facility needs in relation to the population to be served
- An inventory of maintenance backlogs, system and equipment replacement cycles and costs
- An evaluation of alternative financing models, and development of a financing plan for these requirements

Given the fact that this study was conducted within a relatively short time frame, and was necessarily limited to reviewing issues within the Department of Health and Welfare, we are not in a position to say whether, or to what extent, the issues we have identified concerning facility planning, maintenance, and funding are limited to the department, or are more systemic within state government. One purpose of this report was to identify areas that may require further review. The Legislature may wish to consider further study in this area, and as one option, focus on the Department of Health and Welfare as a case study.

Appendix A
Project Scope Summary
October 17, 2005

The Department of Health and Welfare is a very large agency with 9 divisions, an annual budget of approximately $1.6 billion, and staff of more than 3,000 full-time positions. To review the management structure of such a large agency will require significant resources in terms of time, personnel, and money. We will therefore use a multiphase approach to review the department's management structure and provide meaningful information to the Legislature by mid-February.

The purpose of the first phase is to understand how well the department management is doing with respect to some of its key functions and to identify areas that need further study. Key management functions include:

- Communicating with policymakers and stakeholders
- Communicating with line staff, supervisors, program managers, and middle management
- Ensuring resources are used efficiently, program staffing levels are appropriate, and staffing resources and caseloads are fairly distributed
- Ensuring services are provided uniformly statewide

The methodology for this study will include the following components:

- Conduct an agency-wide survey of line staff and supervisors
- Conduct an agency-wide survey of program managers and middle management
- Review the department's methods of managing its caseloads, workloads, and staffing
- Analyze the department's turnover rate
- Review authorizing statutes

The use of this methodology will allow us to address the seven issues raised by Representative Sharon Block in her request for this study:

1. Communication between central and regional offices
2. Consistency of community-based services among regions
3. Communication between upper and middle management
4. Size of middle management
5. Usefulness of strategic plan and performance measures
6. Adequacy of fiscal management and resource allocation
7. Role of the Board of Health and Welfare

Appendix B
Department of Health and Welfare Employee Survey Response Rates

Table 1: Staff and Supervisors

	Surveyed	Responding	Rate
Division of Family & Community Services	**1,444**	**945**	**65.4%**
Adult Mental Health	207	167	80.7
Child Welfare	321	259	80.7
Children's Mental Health	77	60	77.9
Developmental Disabilities	147	119	81.0
Idaho State School and Hospital	333	141	42.3
State Hospital North	82	44	53.7
State Hospital South	236	118	50.0
Other Programs	41	37	90.2
Division of Health	**150**	**123**	**82.0**
Emergency Medical Services	22	18	81.8
Laboratory Services	35	32	91.4
Physical Health Services	59	47	79.7
Vital Statistics	34	26	76.5
Division of Medicaid	**227**	**193**	**85.0**
Facility Standards	42	35	83.3
Medical Assistance Services	185	158	85.4
Division of Welfare	**538**	**457**	**84.9**
Benefits	362	309	85.4
Child Support	158	131	82.9
Welfare Support	18	17	94.4
Indirect Support Services	**247**	**228**	**92.3**
Director's Office	15	12	80.0
Human Resources	16	16	100.0
Information Technology Services	104	100	96.2
Management Services	112	100	89.3
Total	**2,606**	**1,946**	**74.7%**

Table 2: Middle Managers

	Surveyed	Responding	Rate
Division of Family & Community Services	69	66	95.7%
Division of Health	35	26	74.3
Division of Medicaid	20	19	95.0
Division of Welfare	17	14	82.4
Indirect Support Services	18	18	100.0
Total	**159**	**143**	**89.9%**

Note: We did not analyze responses received from middle managers by program because of the small numbers in the survey population.

Source: Analysis of results from the Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, and middle managers, November 2005.

Appendix C
Staff and Supervisors' Survey Responses

The following tables provide department-wide results of our survey of staff and frontline supervisors in the Department of Health and Welfare. The average scores presented in the right-hand column were calculated based on a scale of 1 to 5, where 5 was the most positive response (very good or strongly agree) and 1 was the most negative response (very poor or strongly disagree). Therefore, the higher the score, the more positive the overall response from employees. Each question gave employees the option to indicate they did not know the answer. "Don't know" responses were not included when calculating the percentages for each question.

Table 1: Management and Leadership

	Very Good	Good	Fair	Poor	Very Poor	Average Rating (5-point scale)
1. Rate the quality of leadership provided to employees by each of the following levels of management within the Department of Health and Welfare:						
Upper management (n=1725)	10.9%	30.6%	30.0%	16.2%	12.3%	3.1
Program managers (n=1834)	20.7	37.1	23.8	11.9	6.4	3.5
Frontline supervisors (n=1847)	33.9	35.6	19.6	6.9	4.0	3.9

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
2. I have confidence that the following levels of management have the skills and abilities needed to perform their jobs:						
Upper management (n=1722)	13.5	35.9	28.0	13.6	9.0	3.3
Program managers (n=1846)	20.4	42.9	19.7	12.2	4.8	3.6
Frontline supervisors (n=1847)	27.4	41.9	15.9	10.9	3.8	3.8
3. Goals/objectives are clearly defined at each of the following organizational levels:						
Department (n=1845)	13.6	42.2	21.0	15.6	7.7	3.4
Division (n=1839)	11.3	41.2	22.0	17.5	8.0	3.3
Program (n=1867)	18.2	42.6	17.4	15.5	6.3	3.5

Table continued on next page

Table 1—continued

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
4. I have the opportunity to participate in the process of setting goals and objectives at the following organizational levels:						
Department (n=1841)	4.0%	11.7%	22.1%	34.5%	27.8%	2.3
Division (n=1844)	3.2	12.7	24.7	34.6	24.7	2.4
Program (n=1880)	12.0	30.2	19.6	23.0	15.3	3.0
5. Staff work responsibilities in my program or unit are clear. (n=1913)	23.3	45.3	10.5	15.0	5.9	3.7
6. Cooperation is effective within my						
Division (n=1795)	9.4	33.0	28.4	19.7	9.5	3.1
Program (n=1879)	23.3	41.2	14.9	14.1	6.5	3.6
7. I have the authority I need from superiors to do my job effectively. (n=1917)	26.7	45.4	10.7	11.4	5.8	3.8
8. I have confidence in upper-level management, decision-making. (n=1886)	6.9	24.2	27.4	23.3	18.1	2.8

Table 2: Workload and Staffing

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
1. I generally have enough time to do the work assigned to me. (n=1933)	6.5%	34.4%	10.1%	26.5%	22.5%	2.8
2. The following levels of management regularly monitor staff workload for my program:						
Upper management (n=1536)	3.1	16.0	28.9	29.0	23.0	2.5
Program managers (n=1725)	9.0	36.3	23.2	19.7	11.7	3.1
Frontline supervisors (n=1832)	27.3	45.6	12.8	9.0	5.4	3.8
3. To the extent possible, the following levels of management make adjustments to staff workload when necessary:						
Upper management (n=1603)	2.9	11.4	28.4	28.0	29.3	2.3
Program managers (n=1755)	8.0	29.2	22.8	21.8	18.2	2.9
Frontline supervisors (n=1837)	20.3	43.0	15.4	12.4	9.0	3.5
4. My program or unit has enough staff to carry out its responsibilities. (n=1924)	3.6	18.7	10.3	29.4	37.9	2.2
5. My program or unit has sufficiently qualified staff to carry out its responsibilities. (n=1929)	17.0	38.2	10.8	20.2	13.8	3.2

Table continued on next page

Table 2—continued

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
6. Upper management sets high standards for the services we provide. (n=1849)	19.5%	49.2%	19.7%	7.6%	4.0%	3.7
7. Each employee is held personally accountable for the quality of work he/she produces. (n=1911)	16.4	42.1	12.2	19.1	10.2	3.4
8. To the extent possible, the Department of Health and Welfare rewards (not necessarily monetary) staff on the basis of merit and performance. (n=1876)	2.3	15.8	19.5	29.7	32.6	2.3
9. Workload is appropriately allocated among the staff in my program/office who do the same type of work I do. (n=1892)	8.3	42.8	17.1	18.1	13.7	3.1

Table 3: Policies and Training

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
1. My program has established adequate standards, policies, and procedures to guide me in my work. (n=1931)	13.0%	52.0%	15.2%	14.5%	5.2%	3.5
2. Upper management encourages training and development of its employees. (n=1869)	11.9	41.1	19.0	18.0	9.8	3.3
3. The training I receive is adequate for my current assignment. (n=1929)	9.4	47.0	18.5	18.8	6.4	3.3
4. I have enough time to participate in the training I need for my current assignment. (n=1927)	4.7	31.8	18.8	31.1	13.7	2.8
5. The problem-solving (grievance) process is fair and equitable to all employees. (n=1479)	4.9	22.1	33.3	18.5	21.2	2.7
6. To the extent possible, decisions about promotions are based on merit and performance. (n=1626)	4.2	24.8	24.4	24.0	22.7	2.6
7. To the extent possible, decisions about the distribution of merit raises are made in a fair and equitable fashion. (n=1623)	3.7	20.5	23.9	25.1	26.8	2.5

Table 4: Intradepartmental Communication

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Communication among my co-workers is (n=1939)	31.1%	38.9%	20.1%	6.3%	3.6%	3.9
2. The communication I receive from my supervisor is (n=1937)	34.7	34.2	18.8	6.8	5.4	3.9
3. Overall, communication within the Department of Health and Welfare is (n=1905)	3.3	20.6	41.8	21.0	13.2	2.8

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Score (5-point scale)
4. I receive enough information from top management to do my job well. (n=1884)	5.5%	29.6%	32.1%	21.9%	11.0%	3.0
5. The *InfoNet* is a useful source of information for employees. (n=1914)	16.9	51.9	22.9	6.3	2.0	3.8
6. My supervisor lets me know exactly what is expected of me. (n=1935)	23.7	46.4	15.5	10.7	3.7	3.8
7. The atmosphere in my program encourages people to be open and candid with upper management. (n=1908)	7.8	23.5	20.2	23.6	24.8	2.7
8. I can talk openly with the following levels of management about work-related problems without fear of retaliation:						
Upper management (n=1635)	6.6	17.2	28.0	22.3	26.0	2.6
Program managers (n=1804)	15.2	33.1	17.8	17.5	16.3	3.1
Frontline supervisors (n=1844)	30.5	38.7	12.5	10.3	8.0	3.7
9. The following levels of management encourage my suggestions and complaints:						
Upper management (n=1650)	5.5	19.4	30.8	21.3	23.0	2.6
Program managers (n=1798)	14.0	33.7	21.0	16.4	15.0	3.2
Frontline supervisors (n=1848)	26.8	40.0	16.1	10.4	7.0	3.7
10. The following levels of management listen to the recommendations of staff:						
Upper management (n=1603)	4.1	16.2	31.1	22.8	25.8	2.5
Program managers (n=1784)	12.1	32.3	22.3	17.9	15.4	3.1
Frontline supervisors (n=1839)	24.0	42.9	16.2	9.3	7.7	3.7

Table 5: Morale and Job Satisfaction

		Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1.	Overall, workplace morale among my co-workers is (n=1940)	7.8%	25.3%	28.1%	21.3%	17.5%	2.8

		Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Score (5-point scale)
2.	In general, I am satisfied with my job. (n=1936)	16.6%	48.9%	14.7%	13.5%	6.3%	3.6
3.	Turnover within the Department of Health and Welfare significantly impedes organizational effectiveness. (n=1912)	59.8	30.2	6.5	2.7	0.8	4.5
4.	Management creates an environment that makes me want to do my very best each day. (n=1938)	8.0	26.3	31.8	21.8	12.1	3.0
5.	I feel valued by my supervisor. (n=1925)	34.2	40.0	10.9	8.8	6.1	3.9
6.	I feel valued by the Department of Health and Welfare. (n=1903)	4.2	20.2	28.5	27.3	19.8	2.6

7. In your opinion, what factors have the greatest *positive* impact on employee morale within your work unit or division? (Please rank your top three choices) (n=1926)

	N	Percent		N	Percent
Client interaction	1026	53.3%	Workload	266	13.8%
Pay	897	46.6	Physical work environment	224	11.6
Benefits	640	33.2	Management	218	11.3
Quality of supervision	498	25.9	Promotional opportunities	145	7.5
Recognition	441	22.9	Other	103	5.3
Work schedule	403	20.9	Level of legislative support	74	3.8
Co-worker interaction	388	20.1	Equipment	73	3.8
Level of stress at work	275	14.3	Organizational change	45	2.3

8. In your opinion, what factors have the greatest *negative* impact on employee morale within your work unit or division? (Please rank your top three choices) (n=1930)

	N	Percent		N	Percent
Pay	1239	64.1%	Promotional opportunities	194	10.0%
Level of stress at work	1024	53.0	Recognition	166	8.6
Workload	875	45.3	Benefits	128	6.6
Management	470	24.3	Physical work environment	117	6.1
Level of legislative support	445	23.0	Work schedule	82	4.2
Organizational change	334	17.3	Other	75	3.9
Quality of supervision	281	14.5	Equipment	74	3.8
Client interaction	197	10.2	Co-worker interaction	50	2.6

Table continued on next page

Table 5—continued

9. In your opinion, what are the primary reasons employees choose to leave the Department of Health and Welfare? (Please rank your top three choices) (n=1940)

	N	Percent		N	Percent
Pay	1640	84.5%	Recognition	108	5.6%
Level of stress at work	1027	52.9	Client interaction	107	5.5
Workload	714	36.8	Family reasons	105	5.4
Management	519	26.8	Work schedule	67	3.5
Promotional opportunities	373	19.2	Relocation	66	3.4
Quality of supervision	223	11.5	Other	58	3.0
Organizational change	215	11.1	Physical work environment	52	2.7
Benefits	162	8.4	Co-worker interaction	45	2.3
Level of legislative support	145	7.5	Return to school	30	1.5
Retirement	119	6.1	Equipment	10	0.5

Note: Percents may not sum to 100 due to rounding.

n = number of responses, per question.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare staff and supervisors, November 2005.

Appendix D
Middle Managers' Survey Responses

The following tables provide department-wide results of our survey of middle managers in the Department of Health and Welfare. The average scores presented in the right-hand column were calculated based on a scale of 1 to 5, where 5 was the most positive response (very good or strongly agree) and 1 was the most negative response (very poor or strongly disagree). Therefore, the higher the score, the more positive the overall response from employees. Each question gave employees the option to indicate they did not know the answer. "Don't know" responses were not included when calculating the percentages for each question.

Table 1: Management and Leadership

	Very Good	Good	Fair	Poor	Very Poor	Average Rating (5-point scale)
1. Rate the quality of leadership by each of the following levels of management within the Department of Health and Welfare:						
Upper management (n=137)	15.3%	33.6%	32.8%	8.8%	9.5%	3.4
Program managers (n=137)	33.6	45.3	16.8	2.9	1.5	4.1
Frontline supervisors (n=128)	32.0	47.7	16.4	3.9	0.0	4.1

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
2. I have confidence the following levels of management have the skills and abilities needed to perform their jobs:						
Upper management (n=136)	17.6	39.0	17.6	19.1	6.6	3.4
Program managers (n=137)	27.7	45.3	19.7	5.8	1.5	3.9
Frontline supervisors (n=131)	23.7	51.1	19.8	5.3	0.0	3.9
3. Goals/objectives are clearly defined at each of the following organizational levels:						
Department (n=139)	14.4	43.9	13.7	22.3	5.8	3.4
Division (n=139)	19.4	36.7	18.0	18.7	7.2	3.4
Program (n=140)	25.7	45.0	12.1	11.4	5.7	3.7

Table continued on next page

Table 1—continued

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
4. I have the opportunity to participate in the process of setting goals and objectives at the following organizational levels:						
Department (n=140)	7.1%	13.6%	15.7%	39.3%	24.3%	2.4
Division (n=140)	15.7	30.0	11.4	25.0	17.9	3.0
Program (n=140)	38.6	39.3	10.0	7.1	5.0	4.0
5. I have the authority I need from superiors to do my job effectively. (n=141)	27.7	39.7	11.3	16.3	5.0	3.7
6. I am given sufficient opportunity to provide input as the budget request for my program or unit is being developed. (n=140)	23.6	32.1	15.0	13.6	15.7	3.3
7. I have an appropriate level of control over the budget that has been set for my program or unit. (n=140)	20.7	30.0	22.1	15.7	11.4	3.3
8. Staff responsibilities in my program or unit are clear. (n=141)	30.5	49.6	9.2	7.1	3.5	4.0
9. Cooperation is effective within my						
Division (n=138)	14.5	37.7	23.2	18.8	5.8	3.4
Program (n=140)	32.1	52.1	7.1	5.7	2.9	4.1
10. I have confidence in upper-level management decision-making. (n=140)	12.9	27.1	22.1	23.6	14.3	3.0

Table 2: Workload and Staffing

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
1. I generally have enough time to do the work assigned to me. (n=143)	2.1%	35.7%	9.8%	37.1%	15.4%	2.7
2. I regularly meet with my staff to review their assignments. (n=143)	32.2	55.2	8.4	4.2	0.0	4.2
3. I routinely monitor staff workload within my program or unit. (n=142)	27.5	66.9	4.9	0.7	0.0	4.2
4. Accurate data is available to assist me in assessing staff workload. (n=140)	9.3	48.6	23.6	17.1	1.4	3.5
5. I have the authority I need to appropriately allocate workload within my program or unit. (n=143)	28.0	45.5	9.1	14.0	3.5	3.8

Table continued on next page

Table 2—continued

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
6. Upper management has a clear understanding of the workload in my program area. (n=141)	5.7%	19.1%	21.3%	35.5%	18.4%	2.6
7. Upper-level management distributes resources, including staff, appropriately to my program or unit. (n=142)	4.9	26.8	23.2	27.5	17.6	2.7
8. My program or unit has enough staff to carry out its responsibilities. (n=142)	2.1	19.7	12.7	40.8	24.6	2.3
9. My program or unit has sufficiently qualified staff to carry out its responsibilities. (n=142)	22.5	34.5	14.1	25.4	3.5	3.5
10. High service and productivity standards have been set for staff in my program or unit. (n=143)	36.4	52.4	7.0	3.5	0.7	4.2
11. Department employees are held accountable for the work they produce. (n=142)	19.0	45.1	16.2	16.2	3.5	3.6
12. The department rewards (not necessarily monetarily) staff on the basis of merit and performance. (n=143)	0.7	21.0	24.5	36.4	17.5	2.5

Table 3: Policies and Training

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Rating (5-point scale)
1. My job responsibilities are clear. (n=143)	23.8%	50.3%	14.0%	11.9%	0.0%	3.9
2. The department's strategic plan appropriately guides the agency. (n=141)	9.2	35.5	31.2	19.9	4.3	3.3
3. My division has established clear policies to guide me in managing my program or unit. (n=142)	13.4	42.3	20.4	16.9	7.0	3.4
4. Upper-level management supports department policies. (n=139)	14.4	43.9	22.3	16.5	2.9	3.5
5. The problem-solving (grievance) process is fair for all employees. (n=123)	11.4	37.4	31.7	14.6	4.9	3.4
6. The training I receive from the department adequately prepares me for my management responsibilities. (n=142)	9.9	40.1	26.8	16.9	6.3	3.3
7. I have the abilities to request and receive relevant training. (n=142)	23.9	57.0	12.7	4.2	2.1	4.0

Table 4: Communication

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Communication within or between the following organizational levels is						
From upper-level to my program (n=140)	12.9%	30.0%	26.4%	16.4%	14.3%	3.1
Within my program (n=141)	31.2	46.8	15.6	5.0	1.4	4.0
2. Overall, communication within the department of health and welfare is (n=141)	4.3	31.2	36.9	19.9	7.8	3.0

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Score (5-point scale)
3. The atmosphere within the department encourages candidness between the following groups of employees:						
Program managers with division management (n=137)	13.9%	31.4%	17.5%	22.6%	14.6%	3.1
Line staff and supervisors with program managers (n=141)	23.4	51.8	11.3	8.5	5.0	3.8
4. Employees may talk openly about work-related problems without fear of retaliation from management. (n=140)	15.0	36.4	19.3	15.7	13.6	3.2
5. My input is valued by the next higher level of management. (n=140)	27.1	41.4	13.6	13.6	4.3	3.7
6. I have sufficient access to stakeholders. (n=139)	15.8	57.6	18.0	6.5	2.2	3.8
7. Stakeholders concerns are adequately conveyed to me. (n=140)	10.7	54.3	22.1	10.0	2.9	3.6
8. Legislators have a good understanding of my program's						
Required functions (n=131)	0.0	12.2	17.6	40.5	29.8	2.1
Resource needs (n=133)	0.0	6.0	15.0	42.9	36.1	1.9
9. Legislators' concerns are adequately conveyed to me. (n=137)	8.0	34.3	25.5	20.4	11.7	3.1
10. The department's performance measures adequately inform legislators about the effectiveness of the agency. (n=123)	1.6	23.6	29.3	35.0	10.6	2.7
11. The department effectively uses methods other than its published performance measures to inform legislators about the functions and effectiveness of the agency. (n=108)	4.6	38.9	40.7	11.1	4.6	3.3

Table 5: Morale and Job Satisfaction

	Very Good	Good	Fair	Poor	Very Poor	Average Score (5-point scale)
1. Overall, morale among the people I manage each day is (n=143)	7.7%	44.1%	34.3%	10.5%	3.5%	3.4

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	Average Score (5-point scale)
2. In general, I am satisfied with my job. (n=142)	19.0%	56.3%	8.5%	14.1%	2.1%	3.8
3. Voluntary turnover with the Department of Health and Welfare significantly impedes organizational effectiveness. (n=141)	46.1	34.8	14.2	2.8	2.1	4.2
4. Overall, I feel the following organizational levels are headed in the right direction:						
Department (n=137)	8.0	36.5	31.4	17.5	6.6	3.2
Division (n=137)	18.2	40.9	23.4	13.9	3.6	3.6
Program (n=142)	26.1	51.4	14.8	4.9	2.8	3.9

5. In your opinion, what factors have the greatest *positive* impact on employee morale within your work unit or division? (Please rank your top three choices) (n=143)

	N	Percent		N	Percent
Pay	84	58.7%	Co-worker interaction	23	16.1%
Client Interaction	57	39.9	Promotional opportunities	14	9.8
Recognition	50	35.0	Work schedule	14	9.8
Quality of supervision	37	25.9	Other	12	8.4
Management	33	23.1	Physical work environment	11	7.7
Benefits	28	19.6	Organizational change	7	4.9
Workload	24	16.8	Level of legislative support	6	4.2
Level of stress at work	24	16.8	Equipment	3	2.1

6. In your opinion, what factors have the greatest *negative* impact on employee morale within your work unit or division? (Please rank your top three choices) (n=143)

	N	Percent		N	Percent
Pay	95	66.4%	Other	12	8.4%
Level of stress at work	78	54.5	Quality of supervision	11	7.7
Workload	66	46.2	Benefits	7	4.9
Management	36	25.2	Physical work environment	7	4.9
Level of legislative support	34	23.8	Client Interaction	7	4.9
Organizational change	31	21.7	Work schedule	6	4.2
Recognition	19	13.3	Equipment	1	0.7
Promotional opportunities	15	10.5			

Table continued on next page

Table 5—continued

7. In your opinion, what are the primary reasons employees choose to leave the Department of Health and Welfare? (Please rank your top three choices) (n=143)

	N	Percent		N	Percent
Pay	127	88.8%	Recognition	10	7.0%
Level of stress at work	69	48.3	Family Reasons	10	7.0
Workload	51	35.7	Relocation	8	5.6
Management	38	26.6	Benefits	5	3.5
Promotional opportunities	37	25.9	Work schedule	3	2.1
Organizational change	25	17.5	Return to school	3	2.1
Retirement	14	9.8	Other	3	2.1
Quality of supervision	12	8.4	Client Interaction	2	1.4
Level of legislative support	11	7.7	Physical work environment	1	0.7

Note: Percents may not sum to 100 due to rounding.

n = number of responses, per question.

Source: Office of Performance Evaluations' survey of Department of Health and Welfare middle managers, November 2005.

Appendix E
Establishing a Major Maintenance Reserve Fund

The experience of King County Washington offers an illustration of how a reserve fund can be established and utilized.

Major Maintenance Reserve Fund

In 1997, the King County Council requested inclusion of a Major Maintenance Reserve Fund (MMRF) plan in the executive's 1999 Proposed Budget. The goal was to establish a fully funded plan for major maintenance and repair of county-owned facilities. This comprehensive plan has been fully financed since that time.

The MMRF is a repository and funding source to implement major maintenance projects for county buildings. The program includes an assessment of current and projected major maintenance requirements for over 34 county buildings and incorporates a financing plan to ensure that required improvements can be financed through the establishment of building-based annual charges.

In developing these building-based charges, the county sought to:

- Provide an individualized building-based and stable charge—or "levelized rate"—that would be expected to increase only with inflation.
- Develop a charge methodology that could capture the elements of each of the county-owned buildings, thereby providing a basis for integrating these costs to specific programs benefiting from the use of each building and, where appropriate, to recover these costs from clients (e.g., the Department of Adult and Juvenile Detention can recover costs by including MMRF rates in the amounts charged to cities for housing city prisoners).[1]
- Provide a process for annual evaluation and adoption of these building-based charges, as well as an opportunity to review and approve all proposed projects in the annual budget process.

[1] A methodoloy for determining how to charge building users an annual amount that will go into the reserve fund.

- Provide a process for monitoring and evaluation through mid-year, and an evaluation of the previous year's performance during the annual budget process.

In order to develop this plan, county staff, with the assistance of private sector consultants, began with a comprehensive inventory of maintenance backlogs, system and equipment replacement cycles, and an estimate of long term investment requirements.

King County answered the following inquiries about the MMRF:

- *What other financing plans were considered? What about ideas such as budgeting one percent of initial capital cost for major maintenance?*

  Other financing plans were reviewed, and the one selected was considered the best "hybrid" of sinking fund, pay as you go, and borrowing that the county could develop. Other alternatives would have been more costly, less predictable, and/or less likely to provide cost recovery.

  Ideas such as the 1% major maintenance assessment on all capital projects would provide some funding. However, the estimated life cycle present value equivalent over the building life could be about 25 times that amount.

  The MMRF's reliance on proceeds from sales of county-owned property was also considered. This revenue source was not viewed favorably because most sale proceeds are unavailable for deposit in the MMRF. The proceeds are usually required to benefit the non-current expense fund that owned the property, satisfy debt obligations on the property, and cover the delinquent property tax liability on sales of tax title property. Further, that approach would not provide a predictable and stable funding source.

- *Why did the Executive propose a 10-year financing concept for recovering the costs of immediate projects and reserve deficiencies?*

  Alternative periods of time were considered for recovery of immediate costs and establishment of reserves commensurate with building condition and life. Ten years was selected as a reasonable period because the majority of reserve costs are in 8- to 15-year cycles, and the systems of these buildings were already into those cycles. Further, a longer period for payback of immediate projects would create cash flow problems and delay implementation of needed improvements (unless outside borrowing were employed).

- *How do other jurisdictions finance reserve funds?*

  The county's limited review of other jurisdictions indicated that the problem of reviewing and projecting maintenance requirements and developing a financing plan for these requirements is common to other governments, including the state of Washington. Generally, good plans have not been developed by those jurisdictions, and they face similar issues about matching needs with revenues. Often, the result is either abandonment or major renovation requiring an outside funding source (e.g., special appropriations, grants, or voter-approved bonds). Where examples were available, the private sector was the model we used in evaluating alternatives, and we worked to incorporate the best features of the standard three financing elements of: pay as you go, sinking fund, and borrowing.

  The county imposed the constraint that it would not assume that funding would come from an external source other than building and program beneficiaries (e.g., it did not assume voter-approved tax increases to maintain its infrastructure).

Source: State of Washington, King County Budget Office, *Major Maintenance Reserve Fund* (February 2002).

Responses to the Evaluation

State of Idaho
DIVISION OF FINANCIAL MANAGEMENT
Executive Office of the Governor

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February 23, 2006

Mr. Rakesh Mohan, Director
Office of Performance Evaluations
700 W. State Street, Suite 10
PO Box 83720
Boise, Idaho 83720-0055

Dear Rakesh:

Thank you for this opportunity to respond to the report on Management in the Idaho Department of Health and Welfare (IDHW).

I appreciate the information you provided; however, I have some reservations concerning the overall scope of the review. I believe it is important to provide proper context for the findings that are identified. Thus, it would seem that to fairly assess IDHW's management performance and employee satisfaction, sufficient time should have been provided so that other components, such as comparisons with other state's experiences could have been addressed. It is noteworthy that the most significant and consistent component of frustration on the part of employees begin with compensation issues. Additional coverage may have been helpful regarding experiences in recent years with state funding shortfalls resulting in frozen compensation policies; agency reorganizations that have produced additional stress and communication issues; increased workloads as a result of insufficient funding, etc. as major factors that are normally beyond the agency's immediate control.

Hopefully, there will be sufficient resources in the future to address the concerns that have been raised in your report.

Sincerely,

Brad Foltman, Administrator
Division of Financial Management

BF:ah

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 21, 2006

Mr. Rakesh Mohan, Director
Office of Performance Evaluation
VIA HAND DELIVERY

RE: Study Report on Management in Department of Health and Welfare

Dear Mr. Mohan:

Thank you for the opportunity to respond to the study and report on Management in Department of Health and Welfare.

Our goal is to provide the services that the people of Idaho need and want from their health and human service organization as directed by the Governor and Legislature. It is important to have outside evaluation to determine ways that we can improve services.

The Department of Health and Welfare appreciates the time and effort that the Office of Performance Evaluation put into this project. In a very short period of time, OPE was able to gather some information that provides some basic understanding of how Department management is doing.

We find this study reflects a lot of what the Department has reported to the Legislature, particularly in the areas of pay, morale, workload, and employee turnover. Clearly, all four of these are interrelated.

While the study and report have limitations, we believe the findings are valuable and will be helpful to the Idaho Department of Health and Welfare. We will adopt the recommendations outlined in the Executive Summary and incorporate them into our Continuous Quality Improvement program.

Attached we have included our response where we have highlighted the limitations of the study, the strengths the study found for Health and Welfare, and Next Steps.

Sincerely,

KARL B. KURTZ
Director

KBK/bw
lrmohan2-21-06

I. LIMITATIONS OF STUDY

We believe the results from this study are valuable and will be useful to the Department. However, it is important to acknowledge the limitations of the study in order to put the conclusions into context. Recognizing the limitations will:

- Help all of us examine and interpret the results cautiously.
- Help all us make the right choices in moving forward.

The study and report have three major limitations: Validity and Reliability Issues; Lack of Benchmarks; Upper Management Does Not Control All Staff Behavior.

1. Validity and Reliability of Survey

Anytime a survey instrument is used to make decisions, it is important that the survey be both reliable and valid. There are at least six nationally recognized job and management survey instruments that have been tested as both valid and reliable (for example the Job Satisfaction Survey). In this study the researchers did not use a tested instrument, but wrote their own questions. It is our understanding that while they asked some staff for input on the questions; they did not test for reliability or validity.

Below is a brief description of reliability and validity and why we should be cautious in interpreting the results.

A. Definitions

i. *Reliability* is the degree to which a questions are consistent.

- If you were given five separate questions on morale, your responses should be consistent.

ii. *Validity* is the degree to which a question accurately measures what it is intended to measure.

- If a question is designed to measure communication, it should measure communication, not personal feelings towards management.

- Does the measure assess one basic concept or many different ones? For example, does a question ask just one or multiple things?

B. Examples of Factors Impacting Survey Results

There are a couple of good examples where the survey results may not be what they appear.

i. Reliability and Validity of Confidence in Management Question

An example of a potentially unreliable or invalid question from the study is the question, "I have confidence in upper-level management decision–making." The results from the survey suggest that "more than 41% lack confidence in upper management decision making."

We think this question may be unreliable because almost three-quarters of the same respondents rated the quality of leadership provided to employees by Upper Management as fair to very good.

The reality is that since the question was never tested, neither the Department nor the researchers really know what these results mean. It could indicate staff feelings towards one actual program decision.

ii. Term "Upper Management" Confusing to Some Respondents

About half way through the survey process there were apparently a significant number of people confused by the definition of the term "Upper Management." In response, OPE sent out a more detailed definition to those who had not completed the survey.

iii. Merit and Performance Question

In the Executive Summary, the body of the report, and the conclusions there is a statement or reference to a statement that "more than 60 percent did not feel the department rewards employees on the basis of merit and performance."

The natural conclusion from this observation is that staff are not given pay increases based on merit or performance. We should be very cautious in how we interpret this statement since it is based on a survey question that, even as the consultant who wrote the question acknowledged, is poorly written. The conclusion may or may not reflect what is actually occurring.

The exact question is: "The department rewards (not necessarily monetary) staff on the basis of merit and performance." Results from this question could mean:

- The department does not give non-monetary rewards.
- The department does not give monetary rewards.
- The department rewards based on merit but not performance or vice-versa.
- When the department gives non-monetary rewards, it doesn't do it based on merit.
- Staff are not given pay increases based on merit or performance.
- Any combination of the above.

What the department has concluded is that 60 percent of staff expressed concern about how the department rewards employees either monetarily or non-monetarily.

iv. Validity of Promotion and Merit Question

The report concludes that nearly half of survey respondents disagreed or strongly disagreed with the statement "To the extent possible, decisions about promotions are based on merit and performance."

One of the problems with making conclusions from this one question is whether the question is measuring actual behavior of management or a perception? For example, maybe 50% of staff applied for a position and were denied. A staff member concludes that, "Since I was the most qualified, naturally the department does not promote based on merit and performance."

We should not discount the finding, but we don't know what this means and should not jump to conclusions that promotions are not based on merit and performance.

v. External Factors

We do not know if some of the survey responses may have been influenced by external factors that occurred during the survey process. One story that ran in most newspapers during the survey had a lot of staff nervous. . During the week of November 28th, an AP story circulated around the state entitled, "**Lawmakers want to boost pay of some state workers, lay off others.**" The story stated that, "**Lawmakers** on a special joint committee are recommending that some state programs be eliminated and some state workers be let go so that the pay of some other workers can be made more competitive." The Division of Human Resources received several calls from concerned staff.

C. General Conclusion

On the surface, the survey appears to have "face" validity (i.e. on the face it seems to measure what it is supposed to measure). However, because these questions were not tested, there is no way to determine if the questions are actually measuring what they intended to measure.

We are not suggesting the results be discounted. In fact, we believe the survey results have value. However, this survey should be viewed cautiously and more as a census that provided some general trends.

2. Lack of Benchmarks

The study and report provide little basis for comparison to determine if IDHW is in or outside the norm.

A. Improvements Over Time

Given the limitations of the study, there is no comparison that shows if or how there have been improvements from previous years. There is no argument that IDHW can make improvements. However, IDHW may also be improving from previous years in several areas that were studied.

B. National Averages for Turnover Rates

Another benchmark that would have been helpful is in the area of turnover rates.

There is no argument that IDHW should look at regional or program turnover rates as the report suggests. This will be very valuable information.

However, to fully understand the problem, turnover rates need to be looked at, and compared against comparable jobs at comparable organizations. What are the turnover rates for nurses and social workers in Oregon, Utah, and Montana? What are the turnover rates for nurses and social workers at other state agencies, such as the Health Districts, Department of Correction, Department of Education or the Division of Veterans Services?

Furthermore, it would have been helpful to see if turnover is a national trend. For example, in a study by the Society for Human Resource Management and Career Journal.com (Wall Street Journal), the top two reasons employees are leaving their organization was better compensation elsewhere or career opportunities elsewhere.

Furthermore, slightly more than three-quarters of the currently employed respondents reported they were either activity or passively job searching. In response, many organizations have put into place special practices to improve retention, most commonly offering more competitive salaries.

C. National Survey Norms

The other benchmark that would have been helpful would have been to compare the survey results against any normative data. As mentioned above there are at least six nationally recognized survey instruments that have been tested and validated.

- The Job Satisfaction Survey (JSS)
- The Job Descriptive Index (JDI)
- The Minnesota Satisfaction Questionnaire (MSQ)
- The Job Diagnostic Survey (JDS)
- The Job in General Scale (JIG)
- Michigan Organizational Assessment Questionnaire Subscale

We are aware that at least one of these has normative data available on the internet that gives average responses for different types of organizations. This would have allowed us to compare staff responses from Health and Welfare to national data and comparable organizations.

3. Upper Management Does Not Control All Staff Behavior

The third limitation is that the report did not acknowledge that some of these issues are beyond the direct control of IDHW's management team. For example:

- Since the data indicates that pay is the overwhelming reason for high turnover, the ability to make corrections would need to be a partnership between Health and Welfare, the Governor's Office, and the Legislature.

- Since the data indicates that high stress and workload may be a direct result from a program or unit not having enough staff to carry out its responsibilities, the ability to make corrections would need to be a partnership between Health and Welfare, the Governor's Office, and the Legislature.

- The survey results indicate that morale is made up of many issues that may be beyond IDHW's management control over including pay.

- Some of the concerns that staff express about workload are not a result of management evaluating or not evaluating staffing, but a result of budget cutbacks in FY2002 and FY2003. At this time, while the Department was providing more services, 192 FTE were eliminated. This hit the Division of Welfare particularly hard.

  Per the survey results, this has had a lasting impact since 67.3% of staff either "Disagreed" or "Strongly Disagreed" that their program or unit has enough staff to carry out its responsibilities.

II. STRENGTHS OF HEALTH AND WELFARE

The Idaho Department of Health and Welfare is committed, has trained, and focuses on the organizational principles of Total Quality Management (TQM) and Continuous Quality Management (CQI).

A basic premise of TQM and CQI is to highlight an organization's strengths along with the areas that need improvement. This is important to not only get a complete picture of the organization, but to help guide the organization in making improvements.

The tendency in the report is to focus on the areas where the department needs improvement. By focusing on or drawing attention to only the "needs improvement" areas, an incomplete picture has been drawn of the Idaho Department of Health and Welfare.

We do not want you to delete or minimize any of the findings. These are valuable and will be helpful. However, a more complete picture of the organization will be valuable without taking away from the importance of the findings. In fact, from a Total Quality Management or Continuous Quality Improvement perspective it will strengthen the report.

Below, based upon the results of the study, we have highlighted several areas where the Department Management is performing well.

1. Morale

Both the Executive Summary and the report fail to point out or acknowledge that the majority of staff responded that morale is adequate, and may be good. The survey data indicates that a majority of supervisors and frontline staff – more than 60% – rate morale as fair to very good on a five point scale. (As discussed and agreed upon by OPE, the term "fair" by definition means "satisfactory", adequate", "fine" or "OK".)

Furthermore, as the data suggest, 80.2% rate personal job satisfaction 3 or above on a 5 point scale (5 being high). Based on this information, an inescapable conclusion could be that the majority of staff find morale to be much better than this report leads a reader to believe.

2. Workload

The department valued the suggestion that there are other ways, besides the ones we are using now, to monitor workload.

While staff reported in the survey that they do not think upper management monitors or adjusts workload, the study's findings indicate something different.

There are many situations where upper management actually does monitor and adjust workload. For example, when staff positions are vacated in one region, that position could be reassigned to another based upon a greater need.

Furthermore, staff believe that the frontline supervisors, those who are currently empowered to make decisions about the day-to-day workload issues, do a good job in monitoring and adjusting workload.

- 85.7% of staff gave a ranking of 3 or higher that frontline supervisors regularly monitor staff workload in their program;

- 78.7% of staff gave a ranking of 3 or higher that supervisors make adjustment to staff workload when necessary.

These results suggest that for an overwhelming majority of staff, workload is properly delegated to managers and supervisors and that they are confident in their abilities and knowledge to make day to day adjustments.

3. Confidence in Management

A. Upper Management

The report suggests that staff have mixed feelings about upper management. The report highlights the response to one question which states that more than 40% of staff report they lack confidence in upper management decision-making. However, when looking at the data more carefully, the results indicate that in more ways staff have confidence in upper management.

On a five point scale (with 5 being high):

- 71.5% of staff gave a ranking of 3 or higher to the quality of leadership provided to employees by upper management.
- 72.0% of staff gave a ranking of 3 or higher that upper management encourages training and development of its employees.
- 76.8% of staff gave a ranking of 3 or higher that the goals/objectives are clearly defined at the department level.
- 77.4% of staff gave a ranking of 3 or higher that they have confidence upper management have the skills and abilities needed to perform their jobs.
- 88.4% of staff gave a ranking of 3 or higher that upper management sets high standards for the services we provide.

B. Middle Management and Supervisors

While confidence in upper management is high, it is even higher for middle managers and supervisors. This is important because experience at large companies and research show that for most employees the manager or supervisor is the company. The supervisor is who they work with and turn to when they have questions.

Again, there is room for improvement, but we are pleased to see that the data also clearly shows that our middle managers and supervisors are effective. The survey data indicates that large majority of supervisors and frontline staff rate their confidence in middle management and supervisors as fair to very good on a five point scale. (As mentioned above, we discussed and agreed upon with OPE, that the term "fair" by definition means "satisfactory", adequate", "fine" or "OK".)

- 81.6% of staff report that the quality of leadership provided to employees by program managers is fair to very good.
- 89.1% of staff report that the quality of leadership provided to employees by supervisors is fair to very good.

- 83% of staff have fair to very good confidence that program managers have the skills and abilities needed to perform their jobs.

- 85.2% of staff have fair to very good confidence that supervisors have the skills and abilities needed to perform their jobs.

4. Communication

According to the report, staff rate agency communication as fair, but many raise concerns about the openness of communication.

On the other hand, staff reported very favorable ratings of their ability to communicate with their direct supervisor. This is a very positive trend since, as mentioned above; research indicates that for most employees the supervisor is the company. The supervisor is who they work with and turn to when they have questions.

- 81.7% of staff report that their ability to talk openly with their frontline supervisors about work-related problems is fair to very good.

- 82.9% of staff report that their frontline supervisors' encouragement of suggestions and complaints is fair to very good.

- 83.1% of staff report that their frontline supervisors' listen to the recommendations as fair to very good.

- 87.7% of staff report the communication they receive from their supervisor is fair to very good.

III. NEXT STEPS

The findings have value and will be helpful to the Idaho Department of Health and Welfare.

In many ways, the survey confirms what we have been sharing with the Legislature for some time. The combination of staff reductions, increased workload, minimal adjustments in employee compensation over an extended period of time have inevitably led to increased stress and decreased morale, negative audit findings and, yes, high turnover.

The findings also point out ways that we can improve. We will adopt the recommendations outlined in the Executive Summary and incorporate them into our Continuous Quality Improvement program.

OPE Comments to the Department of Health and Welfare Response

We appreciate the efforts of those who reviewed the report and provided feedback. We offer the following comments regarding issues raised in the Department of Health and Welfare's response.

Survey Reliability and Validity

In its response, the department raises concerns about the reliability and validity of the surveys we conducted of department staff and middle managers. We believe the survey results are both valid and reliable. To ensure questions used in the survey would yield accurate information about issues important to the Legislature, we took a number of steps including:

- Used questions from previous OPE surveys and from questionnaires used in other states
- Consulted with four BSU professors who have experience in survey research to assist in developing the questionnaires and analyzing the survey results
- Conducted group interviews with approximately 60 staff and middle managers in two regional offices and the central office to test questions and ensure they were clear and meaningful. We also asked staff in some of the department's smaller field offices to provide feedback through e-mail. We used the input received from department employees to refine survey questions.

Interpretation of Survey Results

Throughout its response, the department comments on responses to specific survey items. We believe the department has made two fundamental mistakes in interpreting the survey results.

- First, it appears the department consistently discounts survey responses that cast management in a negative light, while accepting as valid those that reflect well on the department.

- Second, the department is attempting to portray the survey results in a more positive light by suggesting that the middle value on the scale means "satisfactory," "adequate," "fine," or "OK." However, as the midpoint on a five-point scale, a rating of fair actually represents "neither good nor poor." As such, fair ratings should not be incorporated into the positive responses, or interpreted to reflect positively on the organization (just as they should not be incorporated into the negative values or interpreted to reflect negatively on the organization).

Balance of Report Presentation

The agency's response suggests the report provides an incomplete picture of the department "by focusing on or drawing attention to only the 'needs improvement' areas." We believe the report provides a balanced picture of management's performance. Although the report highlights key problem areas, it also presents positive findings where appropriate. For example, we report:

- Staff generally gave favorable ratings to the management skills and abilities of department managers
- Staff gave positive ratings to the quality of leadership management provides to its employees
- Staff reported that the department has adequate policies and standards in place for guidance in its work
- Staff believed they receive adequate training for their current work assignment
- Middle managers reported that they have adequate authority to carry out their job responsibilities
- Employees were generally satisfied with their jobs
- Staff gave high marks to communications with their co-workers and immediate supervisors
- Employees felt the department's *Infonet* system was a valuable source of information
- The Resource Utilization System used in the Division of Welfare provides valuable information about program workload, and could be used as a model for other programs
- The Division of Family and Community Services is taking steps to improve caseload and workload information.

In addition, we provided a summary of the responses to *all* survey items in the appendices included at the end of the report.

One of the purposes of this study was to identify areas that may warrant more in-depth review. The survey was used as a tool to identify potential problem areas. Given the timeframe for the review, we sought input from those best able to comment on management, communication, and morale within the department—Health and Welfare employees. The high response rate for the surveys adds to the weight of the findings.

Finally, although the survey results were used to identify possible areas for further study, no recommendation is made based solely on survey findings. In each of the areas where recommendations are offered, we performed additional audit work to develop our findings and recommendations.

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